July, 1955

Medical Economics

A Hotfoot From the Hospital Administrator

Also in this issue:

Malpractice Postscripts

'Blue Shield Didn't Pay Me Enough'

The A.M.A. Report on Unethical Practices

Rx INFORMATION

TACE

INDICATIONS: Menopause, prostatic carcinoma, postpartum breast engorgement.

COMPOSITION: Each capsule, or 1 cc., contains 12 mg. of TACE (Chlorotrianisene).

SAFETY: TACE produces a minimal incidence of withdrawal bleeding so commonly observed following estrogen therapy of the menopause. In both sexes, TACE is generally well tolerated, thus minimizing such side effects as nausea, vomiting and fluid retention.

DOSAGE: For relief of menopausal symptoms, 2 TACE Capsules, or 2 cc. TACE Oral Drops (in cold water), daily for thirty days, is generally a course of therapy. In severe cases when symptoms recur, additional short courses of TACE may be required. For postpartum breast engorgement, 4 TACE Capsules daily for seven days. For palliative control of prostatic carcinoma, 1 or 2 TACE Capsules daily.

SUPPLIED: In bottles of 70 and 350 capsules; in 30 cc. bottles with calibrated dropper. One bottle of capsules or 2 bottles of oral drops usually suffice for a course of therapy.

References: [illegible]

The Wm. S. Merrell Company
CINCINNATI
New York • St. Thomas, Ontario
[illegible]

TACE... released like a hormonal secretion for your menopause patient

TACE, by virtue of its storage in body fat,[1] simulates the hormonal secretion of an endocrine gland by its gradual, even release from this depot.

TACE gives smooth, long-lasting control of symptoms[2]... minimal withdrawal bleeding[3]... and restoration of the "sense of belonging".[4]

A smoother adjustment to the [illegible] with a short, simple course of oral treatment

TACE

ORAL "FAT-STORED ESTROGEN"

Merrell
Since 1828

TACE®

[illegible]

JULY, 1955

Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS.

MORE ▶

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DEPARTMENTS

PANORAMA INDEX

BPA NBP

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Panorama

Percentage payments for practices ruled unethical • Californians launch Society for Nuclear Medicine • Are interneships on the way out? • New ruling on radiologists • Land prices reach new peak

Grand Jury Raps Profit-Seeking Hospitals

Proprietary hospitals have been under fire for some time. But they've rarely been attacked as savagely as in a recent presentment by a Queens County (N.Y.) grand jury.

Based on a two-year investigation, the presentment drips with such terms as "gross negligence," "carelessness," and "inefficiency." It accuses some proprietary hospitals in Queens of being overly concerned with "monetary profit." It charges others with an "utter disregard" for the welfare of surgical patients.

The grand jury also lashes out at the laxness of "existing agencies" in curbing these hospitals. It calls on these agencies to "protect the public as zealously as they protect the doctor."

How much truth is there to the grand jury's verbal pyrotechnics? At this writing, it's difficult to tell. The Department of Hospitals has yet to make an official comment. But it's known the department has felt for some time that laws governing proprietary hospitals aren't stringent enough.

M.D.s Save Health Plans From Consolidation

West Virginia has no fewer than eight Blue Shield plans and six Blue Cross plans within its borders. But when a proposal to enforce their consolidation was introduced in the state legislature recently, the West Virginia medical society was quick to object.

The doctors didn't necessarily oppose some consolidation. But they felt that this particular bill would have given the state insurance commissioner too much power. The state hospital association and the state farm bureau agreed. So did all but one of the Blue Cross and Blue Shield plans. Together they were able to persuade the legislators to table the measure.

Consolidation may still be on the

way. But the next move will probably originate at what the doctors feel is the proper source: the plans themselves.

Percentage Payments for Practices Now Barred

There are a number of ways of paying for a deceased colleague's practice. But one common type of financial agreement that has heretofore been considered both sound and ethical has now been ruled out by the Judicial Council of the A.M.A.: It's unethical, says the Council, for a physician to pay for a practice by simply allotting the deceased doctor's heirs a certain percentage of the income over a period of time.

Argues the Council: "The use of a percentage of fees or an indefinite sum as the purchase price . . . results in dividing fees paid for professional service with a third party who is a stranger to the physician-patient re-

Medical Men Eye Cabinet Change

● **"What do you think of Marion B. Folsom as a successor to Oveta Culp Hobby?" physicians were asking each other last month.**

When it was first rumored that Mrs. Hobby might quit her post as Secretary of Health, Education, and Welfare (ostensibly because of her husband's ill health), the name of Clare Boothe Luce came up as that of a possible replacement. Later, the spotlight shifted to Treasury Under Secretary Folsom.

Now 61, Mr. Folsom enjoys a wide reputation as an authority on pension, welfare, and unemployment insurance plans. He formerly was chairman of the Committee for Economic Development and treasurer of the Eastman Kodak Company.

Snapshots

DRAWING CARD: When A.M.A. President Elmer Hess spoke before the Blaine County (Okla.) Medical Society, there were just eight doctors in his audience. Dr. Hess felt flattered none the less: The turnout was 100 per cent of the society's membership.

TINTED TIRES, which failed to catch on in the austere Thirties and have now been introduced again, will be available in three colors: green, brown, and blue. The color runs from the edge of the white sidewall to the tread. So far, no candy-stripe or polka-dot patterns.

HOSPITAL ACCREDITATION is gathering momentum. The Joint Commission on Accreditation reports that of the 1,376 hospitals it surveyed in 1954—its second year of operation—923 received full approval; 274 more got provisional ratings. This puts the accredited total at 3,513.

DON'T DO IT YOURSELF, some safety experts are beginning to urge. They estimate that home handymen are now getting hurt at the rate of 600,000 a year. The leading accident provokers: ladders, power tools, hand tools.

lationship . . . Further, the Council believes that the use of a percentage arrangement indirectly tends toward solicitation of patients for . . . the purchasing physician, because the seller clearly derives greater profit from greater income."

Does this mean that installment buying is out altogether? Not at all. It's quite all right to pay for a practice on a percentage basis, according to the new ruling, as long as the full purchase price has been agreed on in advance.

The Newest Specialty: Nuclear Medicine

Young as it is, atomic medicine already shows signs of becoming a distinct specialty. One early sign is the formation in California of a Society for Nuclear Medicine.

Membership in the new society isn't restricted to M.D.s. The sixty-odd founding fathers include physicists, biochemists, and technicians, as well as radiologists. The only real prerequisite for joining: an interest and professional competence in the field.

"The peacetime uses of atomic energy have engulfed the medical profession with a flood of unfamiliar problems," says radiologist Henry L. Jaffe, president of the society: "Just as cardiologists get together to compare notes on angina pectoris, so do we intend to pool our knowledge on such subjects as the hematology of radiation, survival methods in an

atomic attack, the clinical application of isotopes, and the hazards to industrial workers and physicians who handle nuclear material . . ."

This sphere of interest, Dr. Jaffe adds, is something that "Hippocrates couldn't have anticipated in his wildest dreams."

Prices Have Climbed; Why Not Fees?

When the plumber, the carpenter, or the grocer raises his prices, the consumer grumbles. But he doesn't kick up nearly so much fuss as when the doctor hikes *his* rates, observes internist William Kaufman.

In a recent issue of Coronet, Dr. Kaufman attempts to show his readers how illogical their attitude toward doctors' fees tends to be. As a case in point, he tells this story about his friend, Bob Roberts:

"Not long ago he had to attend a management meeting in New York City. At the banquet that followed, he ate too much lobster. At 3:00 A.M., he was awakened by a frightful itching. Looking in the mirror, he was horrified to see his face disfigured by a puffy, red swelling. Promptly he called his doctor.

"Half an hour later, the drowsy-voiced doctor arrived at his house and told him: 'You have a case of giant hives. Probably the lobster you ate.'

"Some injections and a few pills gave Bob quick relief . . . Next morning [he] felt fine and was able to go to work. [But] a month later Bob phoned me: 'I've gotten a bill from that doctor—it's robbery!'

"When Bob quieted down, I learned that the bill was for $10. For this, the physician had seen him in the middle of the night and spent half an hour administering medical care. I asked: 'How much do you think he should have charged?'

"Bob thought a moment. 'The last time I had to call a doctor at night, he only charged $5.00.'

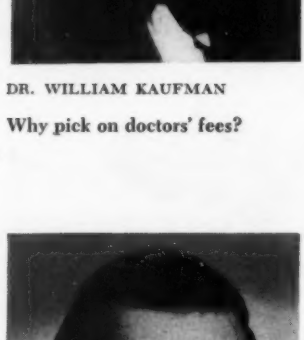
"It turned out that this visit was

DR. HENRY L. JAFFE

In a new age, a new specialty

DR. WILLIAM KAUFMAN

Why pick on doctors' fees?



DR. EDWARD H. LEVEROOS

Interneships could be eliminated

made in 1936, the year you could get a jumbo banana split for 20 cents, send a postcard for a penny, or buy a brand new Ford for $480!"

Interneships Passé?

The interneship is no longer a necessary part of a young M.D.'s education. At least that's the opinion of Dr. Edward H. Leveroos of the A.M.A. Council on Medical Education and Hospitals. Many of the functions of the interneship have been absorbed by the clinical clerkship and by residency training; so interneships could easily be eliminated, he told a meeting of medical educators in Chicago.

Not all his listeners agreed. But one who did—Dr. Ford Hicks, of the University of Illinois College of Medicine—went even further. He charged that in many hospitals today, the interneship isn't fulfilling any educational function whatever. And he suggested that hospitals should hire house officers to do the jobs normally done by internes.

Perhaps, Dr. Hicks added, the salaries of these house officers should be paid by the other physicians on the staff.

Ruling on Radiologists

In Virginia, the controversy over salaried specialists in hospitals has taken a new turn. According to the state's Attorney General, it's perfectly legal for a radiologist to work

for a hospital on salary—as long as he doesn't actually *treat* patients.

This ruling hinges on the Attorney General's definition of the practice of medicine. As he interprets the Virginia law:

"If a radiologist examines a patient, then treats [him] or prescribes treatment for [him], he is, of course, practicing medicine. Here the relationship of doctor-patient exists, and the radiologist [rather than the hospital] should bill the patient . . ."

If, on the other hand, the radiologist limits himself to "furnishing the attending physician with diagnostic aids," he's *not* practicing medicine —at least not under the Virginia code, says the Attorney General. His reasoning:

"The attending physician, not the radiologist, under these circumstances, is actually diagnosing the condition of the patient [and treating him] . . . The relationship of doctor and patient has never existed between the radiologist and the patient."

Watch Out for 'Packed' Prices in Cars

If you've been shopping for a new car, you've probably been offered some sizable discounts. But don't assume that any dealer's an altruist. The fact is, he may have jacked up the list price to begin with—and the "discount" may be pure eyewash.

A study made by the Wall Street Journal shows that this practice

Snapshots

BRAKES CHECKED LATELY? Half the cars on the road have too little hydraulic fluid in their brake mechanisms, says the Association of Casualty and Surety Companies.

SALK EFFECT: Insurance companies have hurried to reduce premiums for polio coverage. But the average cut is only 5 per cent.

HATE-YOUR-DOCTOR WEEK has been proposed by A.M.A. press chief John L. Bach. In such a week, he says, "our everyday critics could unload their gripes and bitterness . . . Then we could all observe the remaining fifty-one weeks as 'Be-Kind-to-Your-Doctor Weeks.'"

PRECEPTOR PROGRAMS, under which medical students make outside rounds with practicing physicians, are on the upgrade. Twenty-two medical schools have instituted such training. Nine of them have made it compulsory.

FLUORIDATION FIGHT is being lost at the polls. Of twenty-five communities that have voted on the question so far this year, only seven have approved fluoridation. Cumulative total to date: 93 municipalities for, 140 against.

(known as "packing") is becoming increasingly general. It isn't illegal, either. The car dealer may charge whatever the traffic will bear.

So, although factory-suggested list prices include the "normal" 24 per cent profit, many dealers tack on an additional couple of hundred dollars.

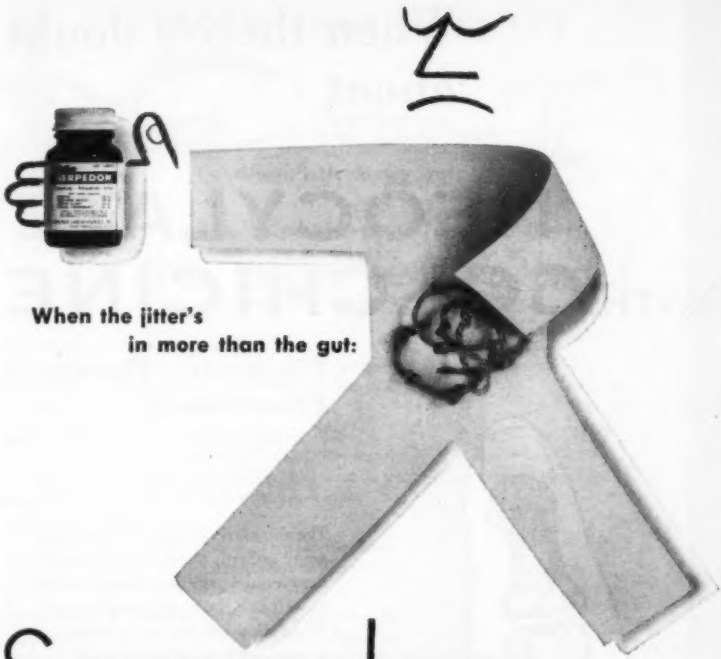
Why don't they just charge the list price *without* a discount? Explained one dealer to a Journal correspondent:

"The buyer has come to expect a dealer to quote a discount of several hundred dollars. That's okay by me so long as it doesn't come out of my pocket. So I just lift the price I quote for the car by a few hundred —the buyer gets his so-called discount, I get my reasonable profit, and everybody's happy."

What such maneuvers mean to *you* is this: Car dealers are in a dickering frame of mind; and chances of making a "deal" are pretty fair if you're willing to work at it. In any case, you'll do well never to accept a dealer's first offer.

Cleared of Nazism

Dr. Godfrey E. Arnold, who was long kept out of the Medical Society of the County of New York because his colleagues suspected he'd once been a Nazi, has finally been admitted. But it took the intervention



Serpedon

the tension-easing antispasmodic

Serpedon* helps you treat the jittery patient with the jittery gut, not just his spasm, which is most likely a symptom of his real trouble: anxiety and tension. Serpedon is 0.1 mg. reserpine, plus three alkaloids of belladonna, equivalent to 7 minims of the tincture. Serpedon rescues the patient from his symptom-producing anxiety and tension with reserpine . . . tranquilizes him, doesn't dull him. Serpedon stops spasm . . . stops it quickly, gives reserpine time to exert its full, tension-easing effect. Recommended dose is one tablet t.i.d. Supplied in bottles of 100 scored tablets. *trademark

Walker Laboratories, Inc., Mount Vernon, New York

of the state medical society to get him in. Here's the story:

A few years ago, the local society's membership committee spent some sixteen months investigating the charge that Dr. Arnold had been a Nazi party member while living in his native Austria. Finally, it decided that the suspicion was unfounded. It voted in favor of his admission, and the comitia minora endorsed the decision.

But the membership refused to go along. At a stormy meeting in April, 1953 (and again in January, 1955), it voted overwhelmingly to keep him out, on grounds that he didn't fulfill the "good character" requirement for admission.

Dr. Arnold appealed to the judicial council of the state medical society. It checked into his background and passed down the final word: There was no evidence that he had ever been a Nazi, and the county medical society would have to admit him.

It was the first time in at least thirty years that the state society had forced a local society to take in a specific individual.

Riot Over M.D.

Anyone think "free choice of physician" is losing its appeal? Not to the Faeroe Islanders, it isn't. Some 3,000 of them recently put up quite a

On the Benefits of

Rauwiloid®

(the alseroxylon fraction of India-Grown Rauwolfia Serpentina, Benth.)

for the Hypertensive

TRANQUILIZING

Rauwiloid produces a tranquilizing effect uncomplicated by dizziness and accompanied by improvement in quality and duration of natural nocturnal sleep. This tranquilizing action begins in a few hours and reaches its peak in a few days.

SEDATIVE BUT NOT SOMNOLESCENT

A feeling of well-being is induced within 24 to 48 hours. Geriatric patients become less cantankerous; younger patients are better able to cope with the stress of daily living—without significant effect on alertness or productive capacity for work.

BRADYCROTIC

If tachycardia is present slowing of the pulse is noted after two or three days on Rauwiloid. This is especially appreciated when cardiac consciousness is part of the clinical picture.

These actions of Rauwiloid are of definite benefit in every grade of hypertension; the more so since Rauwiloid is particularly suited for long-term chronic administration, and is virtually free from side actions and allergenic toxicity. The beneficial influence of Rauwiloid bolsters the hypotensive action of potent drugs, making them effective in lower dosage and greatly reducing their undesirable side actions.

DOSAGE: Simply two 2 mg. tablets at bedtime. After full effect, one tablet usually suffices.

Rauwiloid is a mixture of therapeutically desirable alkaloids, *the alseroxylon fraction*, extracted by an exclusive Riker process, and *only* from roots of Rauwolfia serpentina, Benth., grown in India. Besides reserpine, Rauwiloid contains other active alkaloids such as rescinnamine.

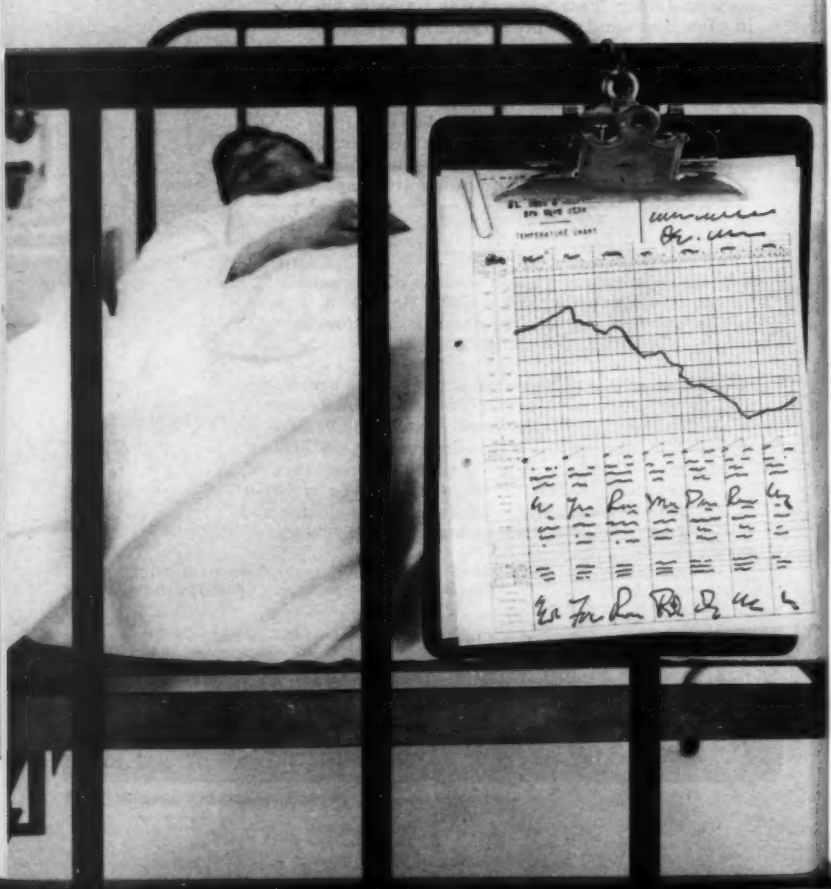
Riker LABORATORIES, INC. LOS ANGELES 54, CALIF.

for the patient with fever,

SF*

means (Pfizer) antibiotic

fortified with vitamin to su



...into to support recovery, speed convalescence

Tetracyn®-SF*

BRAND OF TETRACYCLINE WITH VITAMINS

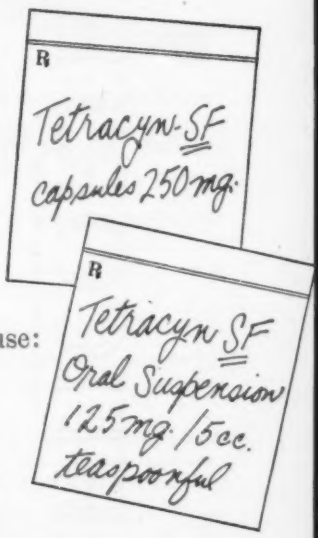
the leading broad-spectrum antibiotic, discovered by Pfizer

with water-soluble vitamins in combinations originated by Pfizer

When treating patients with infections, experience has shown that "one must aim at maintaining the normal daily nutritional requirements, replacing previous depletions and current losses, and supplying whatever increased requirements may be related to the nature of the illness."[1] This modern concept provides the means for "treating the 'whole' patient."[2]

Tetracyn-SF has already demonstrated full antibiotic effectiveness[3] in comparative trials with Tetracyn® (brand of tetracycline) alone and, in the hands of thousands of physicians, has shown

Superior Blood Levels
Superior Toleration
Superior Clinical Effectiveness



Two effective dosage forms for oral use:

Terramycin®-SF* (brand of oxytetracycline with vitamins) is also available.

Tetracyn-SF and Terramycin-SF are formulated to provide the minimum daily dose of each antibiotic (1 Gm. of Tetracyn or Terramycin) plus the stress vitamin formula recommended by the National Research Council.

1. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, Prepared in Collaboration with the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Washington, D. C., 1952; 2. Martí-Ibáñez, F: Antibiotic Med. *1*:247 (May) 1955; 3. Dumas, K. J.; Carlozzi M., and Wright, W. A.: Antibiotic Med. *1*:296 (May) 1955.

*Trademark for the vitamin-fortified antibiotics provided by Pfizer.

Pfizer PFIZER LABORATORIES, Brooklyn 6, N.Y.
Division, Chas. Pfizer & Co., Inc.

fight to retain the doctor of their choice.

The Faeroes, under Danish control, cluster in the North Atlantic, midway between Iceland and the Shetlands. One of these islands, Bordo, has long had only one government-appointed physician. The islanders liked the man. They liked him so well that when Copenhagen tried to replace him, they wouldn't let his replacement off the boat.

When other officials came from the main island, they found crowds of angry citizens swarming menacingly about the wharfs. Meanwhile, the doctor they wanted to keep sat tight in the island's only hospital, still treating patients.

Copenhagen finally sent a detachment of special police to see that the new physician was installed without further delay. And that's when the islanders really got mad: They cut the hawsers of the government ships; they forcibly removed the doctor-replacement; they manhandled the police. In short, they staged a full-fledged riot.

Eventually, the government succeeded in restoring order. But at last report, it hadn't solved the main problem: how to get the islanders to accept a physician of *its* choice.

Land Prices Soar

The cost of living may be leveling off; but the price of the land you live on continues to rise. In most sections of the U.S., a likely plot now costs

for "hot-weather pruritus"

EURAX® lotion

(crotamiton GEIGY)

The problem of summertime skin lesions is essentially one of intolerable itching.

EURAX provides an answer—immediate relief of itch in more than 90 per cent of patients.

sunburn · insect bites · heat rash · poison ivy

Moreover, the effect of a single application *lasts* for 6 to 10 hours or more, permitting uninterrupted sleep throughout the night.

Colorless, greaseless and nonstaining, EURAX is invisible following application—especially important when "summer pruritus" affects exposed parts of the body.

EURAX® (brand of crotamiton) Lotion is available in 2 oz. prescription bottles, and larger size dispensing bottles. Also available—EURAX Cream in tubes of 20 Gm. and 60 Gm., and 1 lb. dispensing jars.

Geigy

GEIGY PHARMACEUTICALS
Division of Geigy Chemical Corporation, 220 Church Street, New York 13, N.Y. *In Canada:* Geigy Pharmaceuticals, Montreal

61738

almost twice as much as it would have in 1946. Between 1953 and 1954 alone, says the Federal Housing Administration, over-all land prices soared an estimated 17 per cent.

What's behind this skyrocketing? A recent spot survey by U.S. News & World Report reveals at least some of the answers:

1. There's a growing shortage of desirable land—particularly around the big cities. And small wonder: "More than 8.7 million new houses and apartments have been put up in the past nine years," says the publication. "They are going up now at the rate of 1.3 million a year."

2. Basic land costs are increasingly inflated by "additional and costly rules for builders and buyers." Some communities, for example, are burdening new neighborhoods "with more than their share of the cost of water and sewer developments."

3. The country's economy continues to prosper. People have plenty of money to buy land; and, naturally, as the demand goes up, so does the price.

Will the inflation of land prices put an eventual stop to the building boom? It's possible; but builders polled don't expect an early slowdown. Their contention: As long as there's easy credit, people will keep on buying. END

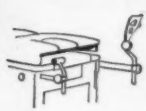
A good milk to travel on . . . and it's available everywhere

You can help young parents enjoy a more relaxing vacation . . . without the anxiety of *hunting* for baby's milk. Recommend Pet Evaporated Milk . . . it's easy to find in grocery stores anywhere. And whenever and wherever it's obtained, Pet Milk is *always* uniform in composition and quality . . . a milk you can *really* depend on.

Favored Form of Milk
For Infant Formula

PET MILK COMPANY, ARCADE BUILDING, ST. LOUIS 1, MO.

Table shown is from the handsome Nu-Trend suite. But the brilliant new beauty and efficiency are typical of all Hamilton equipment . . . Fully adjustable Fit-All stirrups, for example, can now be moved in and out of concealment without lifting table's foot end . . . Plastic paper cutter for the clean STER-O-SHEET table covers is now both adjustable and removable.



ALL NEW... and still first for functional beauty

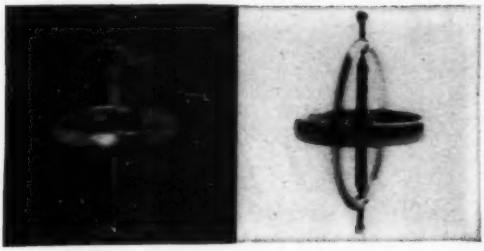
Patience was a key word in the development of the new Hamilton examining room equipment. Patience till the finest built was built even better . . . features already famous for efficiency and convenience, actually improved . . . designs, finishes, and upholsteries evolved to make your office more attractive and pleasant to work in than ever before.

That it was well worth the waiting, you'll surely agree when you look through the intriguing new five-color Hamilton catalog. Write today for your free copy; better still, see your Hamilton dealer.

HAMILTON MANUFACTURING COMPANY
Two Rivers 10, Wisconsin

Hamilton
SURGICAL EQUIPMENT

a non-barbiturate, non-habit-forming, tranquilizing and stabilizing agent



RAU-SED

(Squibb Reserpine)

Rau-sed may be employed to achieve a calming, tranquilizing effect. Rau-sed may be found useful in situations accompanied by stress and anxiety and has been reported helpful in a number of physical disorders with associated emotional overlay (such as headache, dermatologic disorders, gynecologic disorders, enuresis, etc.).

Oral Dosage for Office Practice: The usual daily dose may range from 0.25 mg. to 1.5 mg. Dosage may start with 0.25 mg. t.i.d., and may be adjusted upward or downward. It is important, in adjusting Rau-sed dosage, to consider that results may not appear for one to two weeks after therapy is instituted. When a maintenance level is achieved, Rau-sed may be given as a single daily dose or in divided doses, as the patient prefers. Some patients may need and tolerate higher dosage; in such patients, Rau-sed has proved most effective in conjunction with psychotherapy. *Note:* Patients receiving large doses, or those who receive the drug over a long period, should be watched for signs of depression; this can be alleviated by reducing the dosage or withdrawing the drug.

Supply: 0.1 mg. and 0.25 mg. tablets, bottles of 100 and 1000; 0.5 mg. tablets (scored), bottles of 50 and 500; 1.0 mg. tablets (scored), bottles of 30, 100, and 500; 4.0 mg. tablets (scored), bottles of 100 and 1000 (for psychiatric use). RAU-SED Parenteral, for the treatment of hospitalized psychiatric patients, 5.0 mg. and 10.0 mg. ampuls.

SQUIBB A NAME YOU CAN TRUST

"RAU-SED" IS A SQUIBB TRADEMARK

Enriched Bread...

Low Cost Insurance Against Nutritional Ills

In recent years the improved pattern of foods consumed in the United States has largely eliminated frank forms of nutritional deficiency diseases. This great gain in public health is attributable in large measure to the nationwide distribution of nutritionally improved staple foods, well exemplified by enriched bread.[1] "Such improvement of foods in the United States has been described as low-cost insurance against nutritional ills."[2,3]

Present-day enriched white bread, enhanced in B vitamins, minerals, and milk protein content, serves as an important nutritional protection to consumers. In particular, low-income groups, who eat large amounts of enriched bread because of its low cost, benefit by its high nutritional values.[3]

Wherever sold, enriched bread complies with the federal definition and standard for the product. Per pound, enriched bread provides at least 1.1 mg. of thiamine, 0.7 mg. of riboflavin, 10 mg. of niacin, and 8 mg. of iron. By and large, it also supplies about 400 mg. of calcium and 39 grams of protein. Since the protein consists of flour and milk proteins, it is biologically effective for growth as well as tissue maintenance. Enriched bread is one of the reasons why "We are a nation . . . fed on a plane of nutrition unequalled anywhere in the world."[4]

1. King, C. G.: Newer Concepts of Optimum Nutrition, Food Technol. *8*:486 (Nov.) 1954.
2. U.S. National Office of Vital Statistics: Vital Statistics of the United States, 1948. Part I. Washington, D.C., U.S. Government Printing Office, 1950.
3. Sebrell, W. H.: Developing Modern Nutrition Programs, Public Health Reports, United States Department of Health, Education, and Welfare *69*:277 (Mar.) 1954.
4. Josephson, D. V.: Review of Chemical Mechanisms Affecting Flavor Acceptability of Dairy Products. J. Agr. & Food Chem. *2*:1182 (Nov.) 1954.

The nutritional statements made in this advertisement have been reviewed and found consistent with the best current scientific opinion by the Council on Foods and Nutrition of the American Medical Association.

AMERICAN BAKERS ASSOCIATION

20 NORTH WACKER DRIVE • CHICAGO 6, ILLINOIS

Patch tests on 211 volunteers

were recently performed in an independent clinical study;[1] these tests sought to reveal any possible irritation or sensitization that might occur among patients

using Abbott's new topical anesthetic

—Tronothane Hydrochloride. / The jelly, cream, solution, and a placebo jelly were tested by the Schwartz and Peck technique.[2] Results of this Tronothane study sharply

point up its negligible incidence

of reaction: two persons reacted moderately to the tests (but also to the placebo); the other 209 showed no untoward effect whatever. / Such relative safety from the chance

of irritation and sensitization

makes non-"caine" Tronothane unusually desirable . . . in the relief of pain or itch from episiotomy, hemorrhoids, rectal surgery, pruritus ani and vulvae, dermatoses, minor burns and sunburns, etc. Abbott

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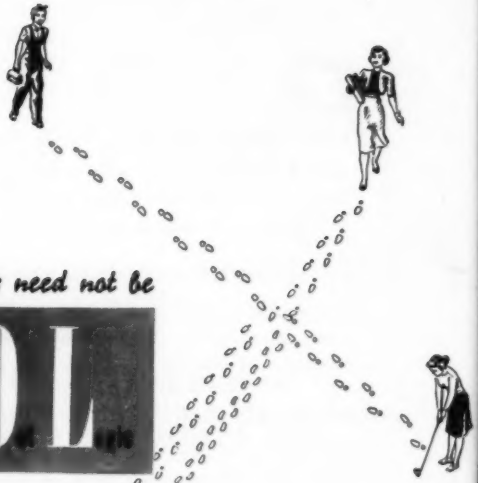
HYDROCHLORIDE
(Pramoxine Hydrochloride, Abbott)

cream
sterile jelly
topical solution
compound lotion

1. Communication to Abbott, Richard E. Weiss, M.D.
2. Schwartz and Peck, Reprint No. 2552, Public Health Reports, Vol. 59, No. 17, (April 28, 1944).

007178



Today your patients need not be

A W O L

in

All Walks Of Life

Women in all walks of life find TAMPAX intravaginal tampons a more comfortable, improved method of menstrual hygiene, permitting uninterrupted pursuit of their activities.

Enthusiastic approval by the medical profession, as well as continued use by innumerable thousands of patients, indicate the high degree of satisfaction inherent in the TAMPAX technique of absorption of the menses.

Three Absorbancies: Regular, Super, and Junior

COMFORTABLE · CONVENIENT · SAFE

PROFESSIONAL SAMPLES ON REQUEST

TAMPAX

the intravaginal menstrual guard of choice

TAMPAX INCORPORATED · PALMER, MASS.

ME-75

free from premenstrual tension

Now she can smile and be gay on every day

She can hardly believe that she's the same person who used to be a jumble of conflicting emotions, uncontrolled temper, hypersensitive attitudes, and peevish disposition for many dismal days each month.

With M-Minus 5 the characteristic emotional impact of the premenstrual tension syndrome can be averted in 82% of cases.[1]

1. Vainder, M.: Indus. Med. & Surg., 22:183, 1953

Each tablet contains:
Pamabrom 50 mg.
Acetophenetidin 100 mg.

M-Minus® 5

Premenstrual Diuretic and Analgesic for Treatment of Premenstrual Tension and Dysmenorrhea

Whittier LABORATORIES, 919 N. Michigan Ave., Chicago 11, Ill.

For the ARTHRITIC

Specify **ERTRON** STEROID COMPLEX WHITTIER

a surer return to normal daily activities

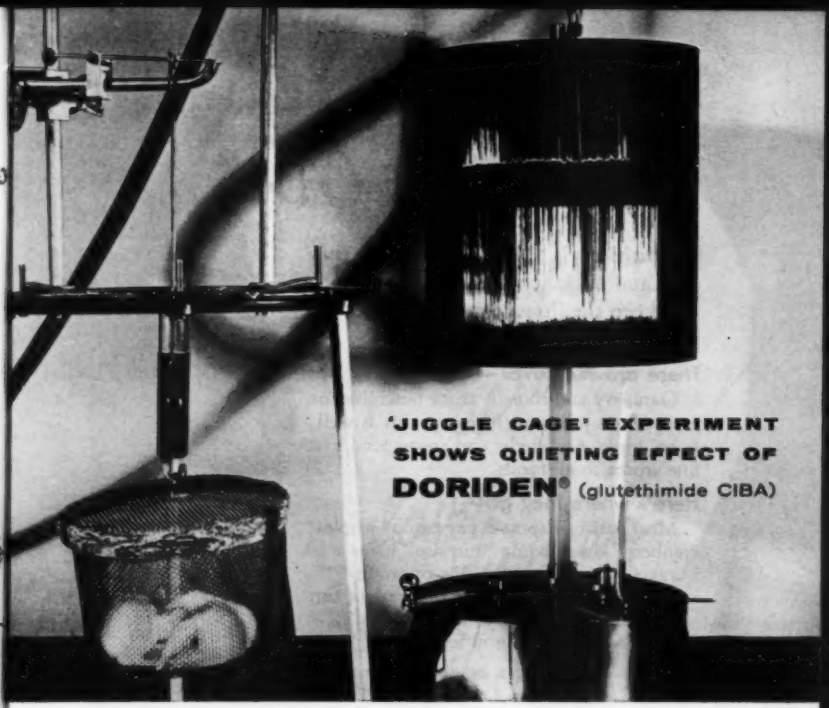
CLINICALLY ESTABLISHED
by carefully controlled studies as therapeutically effective

DEPENDABLY BENEFICIAL
relieves pain; reduces stiffness and swelling; increases mobility

SUSTAINED IMPROVEMENT
in many cases permanent improvement without further medication

Capsules and Parenteral
Also Ertron S-M with Salicylamide and Mephenesin

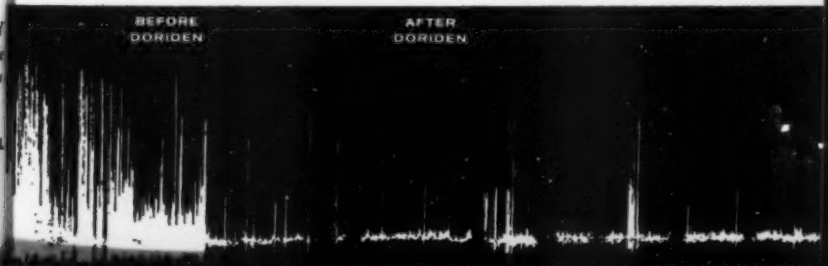
Whittier LABORATORIES
919 N. Michigan Ave. • Chicago 11, Ill.



That **DORIDEN**—a totally new nonbarbiturate hypnotic and sedative—is effective as a quieting agent is demonstrated by this pneumatic movement recorder (jiggle cage), which measures the activity of laboratory animals. Note the marked change in the activity of mice after the administration of DORIDEN. Further evidence of the sedative and hypnotic effectiveness of DORIDEN is provided by numerous clinical studies. DORIDEN acts in 15 to 30 minutes and affords 4 to 8 hours of sound refreshing sleep. Present clinical evidence indicates it is not habit forming.

Tablets (white, scored), 0.25 and 0.5 Gm. **C I B A** SUMMIT, N. J.

2/8136M



"Taste Appeal" for the Low-Fat Low-Cholesterol Diet

Palatability is the key to planning this diet, and these flavor tips will help you keep the "taste appeal" in your patient's diet.

These are for flavor—

Cranberry and tomato sauce pinch-hit for gravy. Fruit juices are to baste with as well as to drink. And herbs and spices lend a fine aroma to all foods.

Here's where they go—

Meat loaf can sport a gay cap of whole-cranberry sauce, while "surprise" hamburgers hide a slice of pickle or onion between two thin patties. Your patient can glaze lamb chops with mint jelly. And kabobs add something different.

Most vegetables can be dressed simply with an herb vinegar. On green salads, cottage cheese thinned with lemon juice, sparked with paprika makes the dressing. And on fruits, try lemon juice, honey, and chopped mint.

For dessert, angel cake goes nicely under fruits—skim milk powder makes the "whipped cream." Snow pudding is a simple dessert—fresh fruit, even more so.

These "diet do's" will help keep your patient happy within the limits of the diet you prescribe.

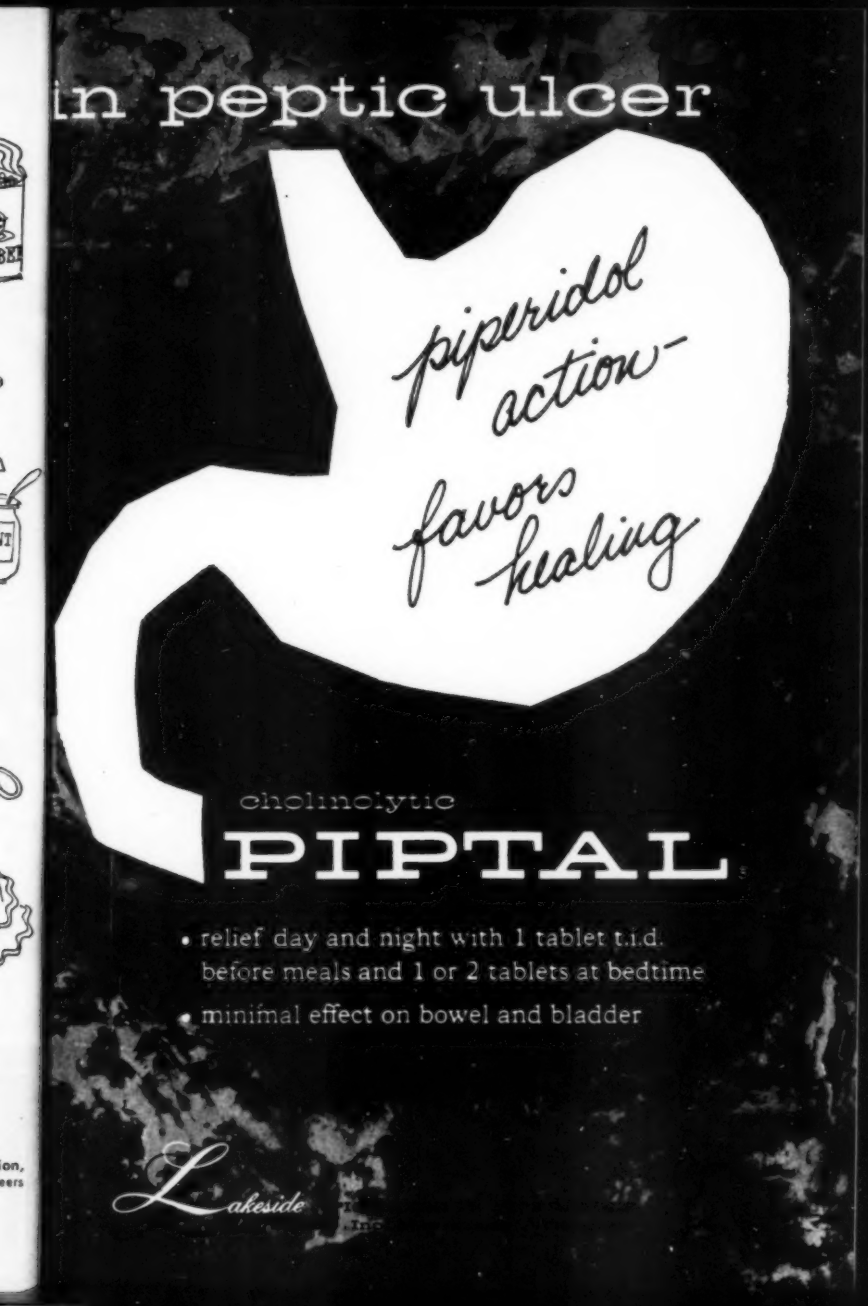
United States Brewers Foundation

Beer—America's Beverage of Moderation

Fat—0; Calories 104/8 oz. glass*

If you'd like reprints of 12 different diets, please write United States Brewers Foundation, 535 Fifth Avenue, New York 17, N. Y.

*Average of American beers


in peptic ulcer
piperidol action—
favors healing
cholinolytic
PIPTAL
• relief day and night with 1 tablet t.i.d. before meals and 1 or 2 tablets at bedtime
• minimal effect on bowel and bladder
Lakeside

There **IS** a difference
in ready-to-eat cereals

WHOLE-GRAIN
WHEAT MAKES

Wheat Chex

a nutritionally superior
cereal...

one that you can recommend with confidence. (And...it's made by the makers of Ralston hot whole wheat cereal!)

Bite Size...Crisp...
Nutlike in flavor. People of all ages like Wheat Chex.

PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

INADEQUACY OF PENICILLIN AS A ROUTINE ANTIBIOTIC IN INFANCY

INJECTED PENICILLIN is used routinely by many physicians for small children with acute febrile diseases before exact bacteriological diagnosis is possible and when nausea, vomiting or other conditions make oral medication impractical. However, a common pathogen in infancy is Hemophilus influenzae which may cause a most dangerous laryngotracheitis with obstructive symptoms, or a most devastating type of meningitis. The Hemophilus influenzae organism is little influenced by penicillin. However, streptomycin is well known to be a very effective agent against the organism and can also easily be injected. Some of the broad spectrum antibiotics ordinarily taken by mouth can be given by injection although their use is relatively new.

● **When it is considered wise to** start vigorous parenteral antibiotic therapy in a sick infant before bacteriological diagnosis can be made, most authorities recommend penicillin be supplemented by streptomycin, or one of the broad spectrum antibiotics that can be given by injection be used until the bacteriological etiology can be determined.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and appear periodically in Medical Economics.

Hemorrhoids needn't hurt

Hemorrhoids need not pain, itch or burn. Inflammation, congestion and pressure can be quickly reduced with Anusol Suppositories.

Prompt, lasting relief of pain and itching: Anusol relieves anorectal discomfort almost immediately upon insertion. Action is soothing and decongestive. Relief is prolonged.

Safely: Anusol contains no narcotic, analgesic or anesthetic drug. Thus the danger of masking more serious rectal pathology is eliminated.

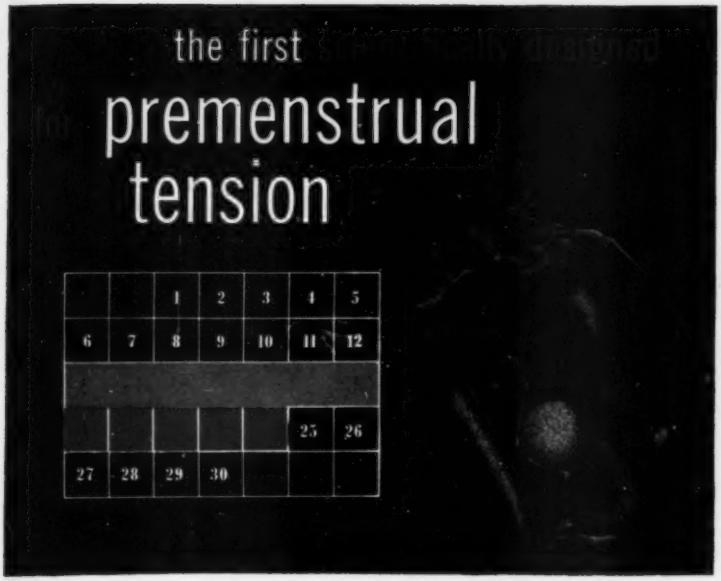
Easily administered: Anusol is easy to insert. Comfort plus efficacy, especially where prolonged use is necessary, contribute to patient acceptance.

Safe in any situation: Because Anusol does not narcotize, the presence of strangulation, ulceration, malignancy or prostatic disease is not concealed. Diagnosis and treatment of co-existing disorders (anal fissures, infected crypts, polyps, warts, abrasions, abscesses, etc.) are not impeded. Anusol does not produce rectal anesthesia which aggravates concurrent constipation.

Dosage: One suppository, morning and night and after each bowel movement.

Packaging: Boxes of 6, 12, 24 individually foil wrapped suppositories.

Anusol®
Suppositories
WARNER-CHILCOTT



neo Bromth®

Brand of Bromaleate, Brayten

NEO BROMTH, the first preparation developed specifically for treatment of premenstrual tension, continues to be found the most satisfactory therapeutic agent in this condition.

Bickers found that "abnormal water storage can be blocked or eliminated and clinical relief of symptoms obtained in most patients . . . "[1] with NEO BROMTH.

Greenblatt recently stated: "Clinically, we share Bickers' enthusiasm for this drug in the management of premenstrual tension, especially where there is associated edema."[2]

NEO BROMTH is non-toxic, *non-hormonal* therapy and contains no ammonium chloride. Each 80 mg. tablet contains 50 mg. of pamabrom (2-amino-2-methyl-1-propanol 8 bromo-theophyllinate) and 30 mg. of pyrilamine maleate.

Dosage: 2 tablets twice daily (morning & night) beginning at onset of symptoms —usually 5 to 7 days before menses. Discontinue at onset of flow. Supplied in bottles of 100 tablets on prescription only.

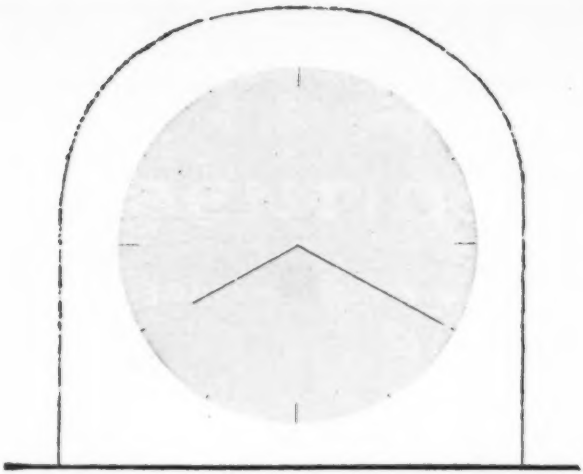
1. Bickers, W.: Southern M.J., 46:873, Sept., 1953
2. Greenblatt, R.: GP, 11:66, March, 1955

BRAYTEN PHARMACEUTICAL COMPANY Chattanooga 9, Tennessee

"That's what I'd call a 'Polysal recovery'!"

Polysal,® a *single* I.V. solution to build electrolyte balance, is recommended for electrolyte and fluid replacement in all medical, surgical and pediatric patients.

Cutter Laboratories, Berkeley, California



round-the-clock antihistamine protection

Green writes: "Last year I obtained for investigational use, the antihistamine chlorprophenpyridamine maleate, so prepared . . . that its resultant therapeutic effect was designed to last approximately twelve hours following the administration of a single oral dose."

After giving this preparation ('Teldrin' *Spansule* capsules) to 357 allergic patients, Green reported:

"The results...confirm the postulated long-acting property and low side effect liability of ['Teldrin' *Spansule* capsules]."

Green, M.A.: Ann. Allergy *12*:273

Teldrin*
chlorprophenpyridamine maleate
Spansule*
brand of sustained release capsules
Antihistamine

In 2 dosage strengths:
8 mg.
(1 dot on capsule) &
12 mg.
(2 dots on capsule)

One 'Teldrin' *Spansule* capsule q12h provides 24-hour uninterrupted, sustained antihistamine protection from a wide range of allergic manifestations.

made only by
Smith, Kline & French Laboratories, Philadelphia
the originators of sustained release oral medication

*T.M. Reg. U.S. Pat. Off. Patent Applied For.

FOR VARICOSE VEINS
FROM BAUER & BLACK

AN **ELASTIC STOCKING** THAT DOESN'T LOOK LIKE ONE

So sheer, your patients will wear it cheerfully—yet it gives correct, graduated support from ankle to thigh

Now you can prescribe elastic stockings that are truly sheer and inconspicuous. So sheer and dressy-looking, in fact, your patients can wear them without overhose. (No patient co-operation problem with *these* stockings.)

Yet sheer as they are, Bauer & Black elastic stockings give proper remedial support. They're knitted with rear-fashioning seam so that pressure is adjusted to leg contours, avoiding undesirable constriction. Pressure decreases gradually from ankle up, gently speeding venous flow.

Shouldn't you prescribe *Bauer & Black* elastic stockings next time? More doctors *do*.

Shaded area indicates correct pressure pattern of Bauer & Black Elastic Stocking.

BAUER & BLACK

ELASTIC STOCKINGS

Division of The Kendall Company
309 West Jackson Blvd., Chicago 6, Ill.

PORTRAIT OF A POOR APPETITE . . .

When a mealtime masterpiece like this is part of your clinical picture,

prescribe TROPHITE*

to stimulate appetite and promote growth.

Each tablet or teaspoonful (5 cc.) provides: 25 mcg. B_{12}; 10 mg. B_1

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

Letters

Chest X-rays for hospital patients • In favor of A.M.A. retirement aid • Should doctors dispense? • Delegating work in medical 'mills' • What to do about unwanted mail • Appendectomy addendum

Union Practice

SIRS: The glowing information in your recent article, "What It's Like to Work for a Union," appears to have been obtained from the full-time supervisor of the Sidney Hillman Health Center, who of course is well paid to be favorable in his views —or else . . .

The most interesting thing about the article, to me, was the care you took to disguise the identity of internist "Josiah Salder." He undoubtedly knows what would happen to his referrals if people in his Brooklyn neighborhood found out about his union work. Protest as he may, what he really does is offer substandard medicine at low fees, dressed up with a fancy physical plant and pretty aides.

Louis M. Soletsky, M.D.
Floral Park, N.Y.

SIRS: . . . An A-1 presser in the clothing line makes more than $4.25 an hour. Yet this is what Dr. Salder's pay amounts to, if you take traveling time into account and deduct parking costs. And I'm sure that the manager of a union local earns more than this great and venerable specialist does.

No, thank you! I'd rather work for myself as a general practitioner.

H. E. Berg, M.D.
Brooklyn, N.Y.

Doctors vs. Draft

SIRS: Re "The Doctor Draft: Alive and Still Kicking": By our lack of aggressive action, we have created a climate in which the military, the politicians, and the American people now feel that they can make any demands on physicians, however unreasonable . . .

If we do not act immediately, and in concert, future historians may well label the doctor draft as the first great step toward the socialization of American medicine.

Peter J. Kearney, M.D.
Lake Forest, Ill.

SIRS: . . . The average physician, whether 4F or 1A, is just as loyal as the average citizen. And he should

physiologic answer to "morning sickness"

EMETROL®

Phosphorated Carbohydrate Solution

In a controlled study, Crunden and Davis[1] clearly established the value of EMETROL in nausea and vomiting of pregnancy. EMETROL produced favorable responses in 78.8 per cent of 123 patients, as compared with only 14.8 per cent of 122 patients receiving a placebo of like appearance and taste. Relief was usually secured within the first 24 hours of treatment. EMETROL was found to be a *safe, physiologic* agent, free of annoying side actions. Containing no drugs likely to induce untoward effects, EMETROL is easy and pleasant to take, safe for all age groups.[2,3]

DOSAGE: 1 to 2 tablespoonfuls on arising, repeated every three hours or whenever nausea threatens.

IMPORTANT: EMETROL must always be taken *undiluted*. Fluids should not be allowed for at least 15 minutes after each dose.

SUPPLIED: In bottles of 3 fl.oz. and 16 fl.oz. through all pharmacies.

In epidemic vomiting (acute infectious gastroenteritis, intestinal "flu"), EMETROL works rapidly, even in refractory cases; control is usually established with the first few doses, "often with a single dose."[2]

1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311, 1953. 2. Bradley, J. E., et al.: J. Pediat. 38:41, 1951. 3. Tebrock, H. E., and Fisher, M. M.: M. Times 82:271, 1954.

Kinney

Literature and sample on request

KINNEY & COMPANY, INC.
COLUMBUS, INDIANA

be entitled to the same *rights* as the average citizen . . .

Regardless of his previous service in the armed forces, the doctor is today the pawn of pressure groups within medicine and of socialistically inclined politicians. Thus, he's held up to ridicule if he voices his objections to enforced military service. What other class of citizens would accept such discrimination, with no recourse in law?

M.D., New York

Kudos for Alien M.D.s

SIRS: I'm an alien physician—and not the least bit ashamed of it. I believe that a fair analysis of the records of the 10,000 immigrant doctors who have landed on these shores since 1936 would reveal something like the following:

1. Distinguished contribution to American medicine and culture: a goodly percentage.
2. Above-average contribution: a goodly percentage.
3. Average contribution: the majority.
4. Less-than-average contribution: a small number.
5. Poor contribution: very few.

Kenneth I. E. Macleod, M.D.
Ayer, Mass.

'That Eye'

SIRS: All too often, doctors refer to the patient not by his name but as "that eye" or "that thumb." It seems to me that this undesirable habit should be brought to their attention.

I'll bet someone like your cartoonist Al Kaufman could illustrate the point tellingly.

Victor Gregory, M.D.
Portland, Ore.

He could—and has done so. See the sketch below.—ED.

Chest X-rays

SIRS: Dr. F. Dixon Whitworth recently wrote to you, questioning the wisdom of his hospital's ruling that all entering patients are to have routine chest X-rays. His letter stirs me to protest . . .

Such screening projects in general hospitals are widely accepted, not only for the detection of tuberculosis but also for pulmonary cancer, cardiac abnormalities, and industrial diseases of the lungs.

Admittedly, hospital administration is difficult in these times of ris-

ing costs. To the administrator, the addition of another intramural program may appear likely to overtax the hospital. In actual fact, however, the routine admission chest X-ray is one means of *simplifying* administration.

The costs of such a program are moderate. Moreover, these costs can be offset by real savings in compensation insurance premiums and by the intangible dividends of patient and staff safety. In addition, the hospital will enjoy a reputation for good medical care and constructive community service . . .

In the near future, the National Tuberculosis Association will publish a manual on all aspects of establishing chest X-ray screening programs in general hospitals. Such programs are endorsed in principle by the Public Health Service, the V.A., the American Hospital Association, the American College of Radiology, the American Trudeau Society, and the National Conference of Tuberculosis Workers.

Theodore L. Badger, M.D.*
Boston, Mass.

SIRS: Inasmuch as the value of other routine examinations was long ago established, it is difficult to understand Dr. Whitworth's objections . . . Actually, by routine chest X-ray examination, we can find more unsuspected disease than by the rou-

*Dr. Badger is chairman of the Committee on Chest X-ray Screening Programs in General Hospitals, National Tuberculosis Association.

tine blood Wassermann reaction, blood counts, chemistries, and urinalyses.

Contrary to general medical opinion, patients do *not* object to this routine if it is properly explained to them. An increasing number of surgeons and obstetricians in this community are utilizing chest X-ray study as part of the preoperative or prenatal evaluation. These physicians tell me that their patients are entirely willing to pay the additional fee because of the sense of security attained . . .

Sydney Jacobs, M.D.
New Orleans, La.

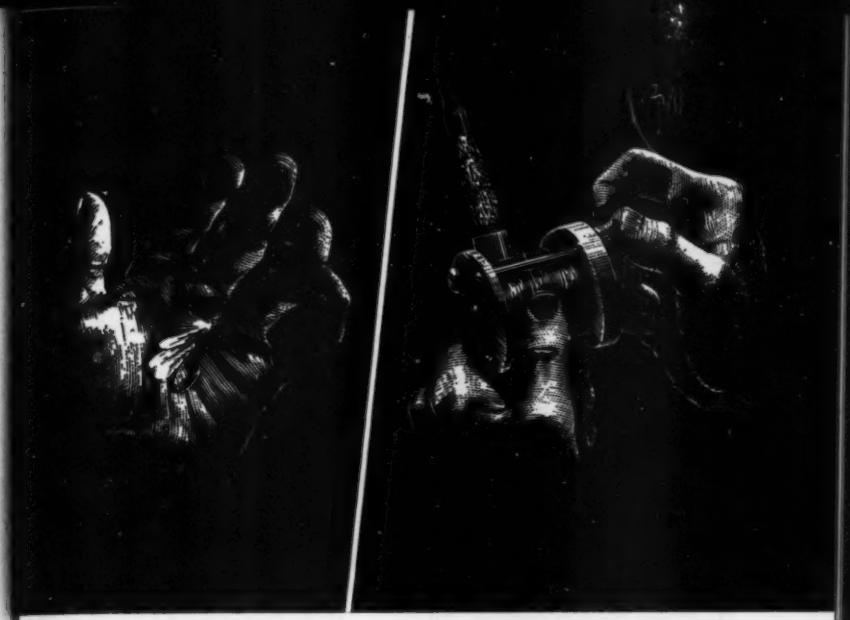
Retirement Aid

SIRS: I heartily endorse Dr. John Peters' proposal that the A.M.A. buy a plot of land in a warm state and build homes there for retired doctors. Many other groups—including ballplayers—have retirement provisions. Why shouldn't we?

James W. Davis, M.D.
Leonard, Tex.

SIRS: . . . Soon after the A.M.A. set up a program to assist needy doctors, I attended a meeting of the Woman's Auxiliary at which the plan was explained. Two young wives expressed amusement at the idea that an M.D. might ever need financial help.

Well, many doctors do. For example, my husband had a carotid artery tied following an accident; and he's now able to work only about



from rigidity to relaxation

When the rigidity and pain of arthritis and related rheumatoid disorders prevent the patient from enjoying a normal, satisfying life, Acetycol may open a road to rehabilitation. Therapy with Acetycol provides welcome relief of pain and increases the range of pain-free movement. Thus the patient is able to resume more normal activities in his work and relaxation.

The effectiveness of Acetycol is based on synergism between aspirin and para-aminobenzoic acid. The combination of these two agents produces high salicylate blood levels on relatively low dosages. Salicylated colchicine extends the effectiveness to cases of a gouty nature.

Acetycol also contains three essential vitamins often lacking in older patients: ascorbic acid, to prevent degenerative changes in connective tissue; thiamine and niacin, for carbohydrate utilization and relief of joint pain and edema.

Usual dosage—1 or 2 tablets three or four times a day.

Each Acetycol tablet contains:

Aspirin	325.0 mg.
Para-aminobenzoic acid	162.0 mg.
Colchicine, salicylated	0.25 mg.
Ascorbic acid	20.0 mg.
Thiamine hydrochloride	5.0 mg.
Niacin	15.0 mg.

Supplied: Bottles of 100 and 500.

Acetycol TRADEMARK

to relieve rheumatic pain

WARNER-CHILCOTT

two-thirds of the time. I, too, have had a number of major operations and am awaiting another. Is it any wonder that I approve Dr. Peters' proposal?

M.D.'s Wife, Idaho

Calling a Consultant

SIRS: In "How to Handle Referrals," Dr. Henry A. Davidson's objective evaluation of the many problems that arise in consultation is superb...

Early in my career, I took an older clinician as my model in solving referral problems. Whenever a consultant might be needed later on, he made it a point to discuss the possibility with the patient or his family. He always explained that he felt he had the case in hand, but that a consultant might be required in a day or so, if the patient didn't show continued progress.

This method showed the family that the doctor was willing to do everything he could for the patient. And it permitted him to have a compelling voice in the selection of a consultant, should the need arise...

Ralph A. Johnson, M.D.
Detroit, Mich.

Dispute on Dispensing

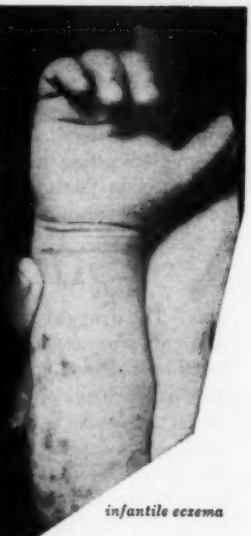
SIRS: I read with interest your recent article, "I Dispense—and I'm Proud of It!" That's my sentiment, too.

In the old days, the local druggist

announcing . . .

combined corticosteroid-antibiotic therapy for dermatologic conditions

. . . including poison ivy and sunburn



infantile eczema

florinef-S

Ointment / Lotion

SQUIBB FLUDROCORTISONE ACETATE WITH SPECTROCIN (SQUIBB NEOMYCIN-GRAMICIDIN)

the anti-inflammatory, anti-pruritic action* of FLORINEF—much more potent than that of topical hydrocortisone	+	the prophylactic action* of SPECTROCIN—effective against many gram-positive and gram-negative organisms

*". . . secondary infection with pustulation often follow scratching which is induced by the intense itching." Nelson, W. E.: Textbook of Pediatrics, ed. 5, Philadelphia, W. B. Saunders Company, 1950, p. 1516.

Supply: Florinef-S Lotion, 0.05 and 0.1 per cent, in 15 ml. plastic squeeze bottles. Florinef-S Ointment, 0.1 per cent, in 5 gram and 20 gram collapsible tubes.

Also available: Florinef Lotion, 0.05, 0.1 and 0.2 per cent, in 15 ml. plastic squeeze bottles. Florinef Ointment, 0.1 and 0.2 per cent, in 5 gram and 20 gram collapsible tubes.

"FLORINEF-S", "FLORINEF" AND "SPECTROCIN" ARE SQUIBB TRADEMARKS

SQUIBB

prepared most medicines from the crude plant sources. So physicians naturally had to call upon him to supply their needs. But nowadays, when medications are prepared and packaged at factories, there is no reason why we should not dispense.

T. A. Darling, M.D.
Agana, Guam

SIRS: The druggist seems happy to draw an arbitrary line between injectable and oral medications. He sells us injectables at cost, and he doesn't raise an eyebrow at any small profit we might turn on them. But he considers it his inalienable right to tap the patient's purse for something like 100 per cent profit on any medication that's taken by mouth . . .

Dispensing is said to deny the patient free choice of pharmacist. By the same token, if the doctor does a blood count or a urinalysis, isn't he denying the patient a free choice of laboratory technician? Yet we haven't heard any complaints on that score—so far.

M.D., Missouri

SIRS: I practice in a rural community. And it often happens that a patient can't get needed medication from the distant drugstore within a reasonable time.

At first, to cope with this situation, I dispensed the necessary

For the hay-fever patient

The patient allergic to seasonal pollens can enjoy summertime to the fullest: 'Co-Pyronil' eliminates distressing symptoms and rarely causes disturbing side-effects.

Because 'Co-Pyronil' is notably long-acting, the patient usually obtains continuous relief without the inconvenience of frequent doses. Also, the bed-time dose often keeps the patient symptom-free throughout the night.

Each pulvule provides the complementary effects of:

'Pyronil' (Pyrrobutamine, Lilly)	15 mg.
'Histadyl' (Thenylpyramine, Lilly)	25 mg.
'Clopane Hydrochloride' (Cyclopentamine Hydrochloride, Lilly)	12.5 mg.

Dose: Usually 1 or 2 pulvules every eight to twelve hours. Increase or decrease as needed.

ALSO

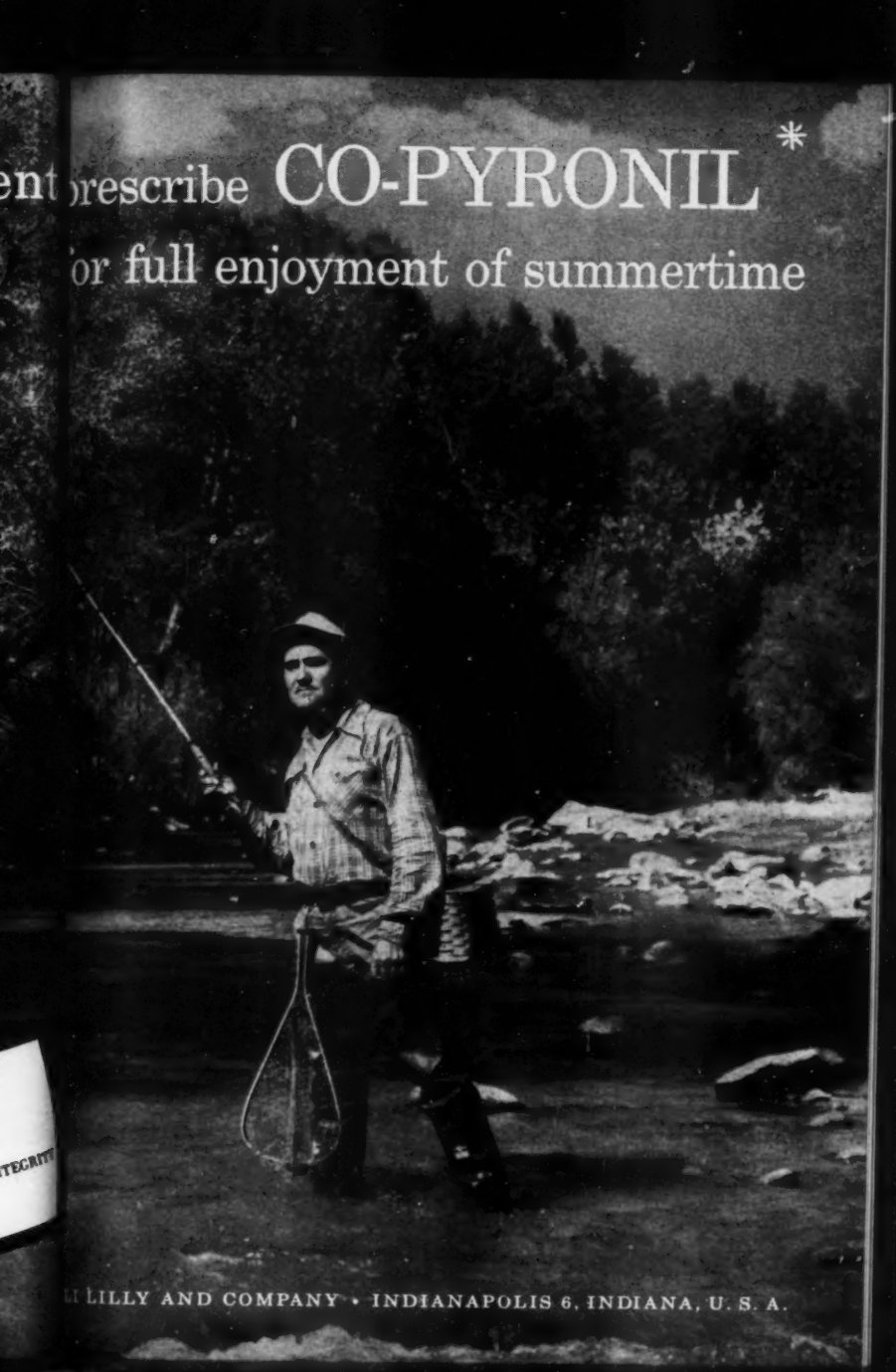
Suspension CO-PYRONIL
One-half the above formula in each 5-cc. teaspoonful. Deliciously flavored.

Pulvules CO-PYRONIL, Pediatric
One-half the above formula in tiny capsules.

Tablets 'Pyronil,' 15 mg.—when 'Pyronil' alone is indicated.

•'Co-Pyronil' (Pyrrobutamine Compound, Lilly)

Lilly
QUALITY / RESEARCH / INTEGRITY


ent prescribe CO-PYRONIL *
for full enjoyment of summertime
LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

drugs. But I soon found that I was getting a reputation for overcharging, since the patient didn't differentiate the visit charge from the drug charge.

So now I've developed a mutually satisfactory system. If, for example, the patient needs twelve tetracycline capsules, I give him four—enough to last twenty-four hours. I write my prescription as follows: "Tetracycline #12 (hold 4)." When the pharmacist fills it later on, he gives the patient eight capsules but charges him for twelve. He then returns my four, thus replenishing my original stock.

Everett W. Forman, M.D.
Prattsville, N.Y.

SIRS: . . . I work in a doctor's office. And I've heard many patients tell my employer he'll have to wait for his money until they see how much the prescription is going to cost. After they've bought the medicine, he gets paid—sometimes.

A good doctor charges on the basis of the patient's ability to pay. But does a druggist ever fill a poor man's prescription for nothing?

Doris Sawyer
Middletown, Ohio

Medical 'Mills'

SIRS: I agree with the author of "I'm *Against* Delegating Work" that medicine should not be put on a mechanized basis. Yet I know of several "mills" where people get in one line for shots, in another for heat

Laxative action... *suited to his routine*

Relief of temporary constipation: Agoral is suited to the acutely constipated patient who can neither take time off for a "purge," nor time-out to answer the sudden urge induced by strong laxatives: the head of a one-man business; the executive committed to a day of important conferences; the bus driver on a long haul; people in the theatre, the pulpit, the factory, the home. For all who need relief of temporary acute constipation, pleasant tasting Agoral provides positive results without urgency.

No urgency; evacuation which adjusts to schedule: A dose taken at bedtime almost invariably produces results the following day. Elimination is comfortably achieved by mild, positive peristaltic action, not by violent paroxysms of unrestrained hyperperistaltis.

No griping; interim discomfort avoided: Agoral's action is sustained uniformly during its passage through the intestinal tract; and it causes no uncomfortable griping, embarrassing flatulence, distention or stomach distress.

Dosage: On retiring, ½ to 1 tablespoonful taken in milk, water, juice or miscible food. Repeat if needed the following morning two hours after eating. Contraindications: symptoms of appendicitis; idiosyncrasy to phenolphthalein.

Supplied: bottles of 6, 10 and 16 fluid-ounces; and as Agoral Plain (without phenolphthalein), bottles of 6 and 16 fluid-ounces.

Agoral®

mineral oil emulsion with phenolphthalein

WARNER-CHILCOTT

treatments, and so on. They may see the doctor for a few minutes every third or fourth call, if they're lucky.

It seems to me that such mass-production techniques produce exactly the impersonal, sloppy medical care that we object to in socialized practice . . .

Hans Pollak, M.D.
Gloversville N.Y.

'Junk' Mail

SIRS: I agree with Dr. Leon Ropschutz that there's too much "junk" advertising in the mails nowadays. And I think our local postmistress has the answer:

She suggests that doctors write "Refused—return to sender" on unwanted mail. If it costs the advertiser money for return postage, he will soon stop sending it.

Laurence H. Ballou, M.D.
Bethel, Vt.

M.D. Insignia

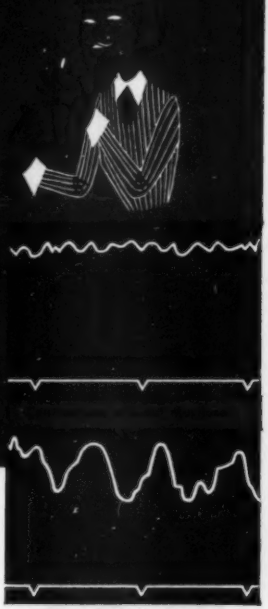
SIRS: Your article, "Where *Can* an M.D. Park?", reports that most doctors feel it's a good idea to have some sort of insignia to facilitate parking. But, as you point out, such identification can invite trouble from narcotics thieves.

I have found a way out of this dilemma: To the outer surface of one of the visors in my car, I've affixed an "M.D." tag. When I want to identify the car, I flip the visor

Superior Effectiveness
Increased Convenience

Mucilose®

For Physiologic Bowel Regulation



2. Contractions 24 hours after ingestion of Mucilose

Mucilose — highly purified hemicellulose from psyllium seed — produces gentle, stimulating, bland bulk, physiologically initiating normal peristaltic waves in the large intestine and at the same time soothing the irritable colon.

Superior Effectiveness

Mucilose absorbs as much as 50 times its weight of water which it effectively retains during passage through the bowel, producing a pliable, demulcent stool.

Increased Convenience

To the greater effectiveness of Mucilose is added the increased convenience and flexibility of a variety of dosage forms to meet varied needs:

- **MUCILOSE COMPOUND TABLETS,** Mucilose with methylcellulose; *bottles of 100 and 1000.*
  Greater Bulk · Smaller Dosage · Convenient · Easy to Swallow
- **MUCILOSE SPECIAL FORMULA Flakes or Granules**

Also

- **MUCILOSE CONCENTRATED Flakes**

in tins of 4 oz. and 1 lb.

Mucilose should be taken with 1 or 2 glasses of water.

NEW YORK 18, N.Y. WINDSOR, ONT.

Mucilose trademark reg. U.S. Pat. Off.

down. But when the visor is up, there's nothing to indicate that the auto is a physician's.

W. D. Blassingame, M.D.
Denison, Tex.

Autoappendectomy

SIRS: This paper greatly appreciates the space you gave to a report on our brainstorm, "You Can Take Out Your Own Appendix." In this parody of today's do-it-yourself article we gave our readers detailed instructions on how to perform the operation (on the dining room table, with a single-edge razor blade).

Evidently the news spread fast. Not long after the column appeared, we got a letter from a young man in England, requesting a copy. He said that, socialized medicine being what it was, he wasn't sure he could wait till a doctor found time to perform the necessary operation. He enclosed an American dollar that someone had given him as a souvenir (or so he said).

I sent him back his dollar, and airmailed a copy of the appendectomy thing, cautioning him about obeying instructions. (I'd heard the English don't always get American humor, and I didn't want to take a chance.)

Jim Comstock, Editor
The News Leader
Richwood, W. Va.

END

for
those

"on the mend"

specify

VITERRA®
THERAPEUTIC

Therapeutic formula
11 minerals, 9 vitamins—
for prompt nutritional
recovery following
illness. All in one soft
gelatin capsule.

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those

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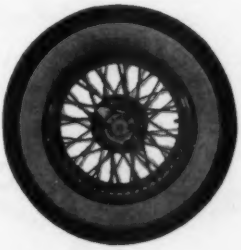
ideal as the prophylactic
mineral-vitamin capsule.
All in one soft gelatin capsule.



Balanced formulae: for balanced nutrition ROERIG *Chicago 11, Illinois*

Will not burn or irritate the eyes. Contains no toxic or sensitizing ingredients. Cleanses thoroughly; leaves hair soft and manageable.

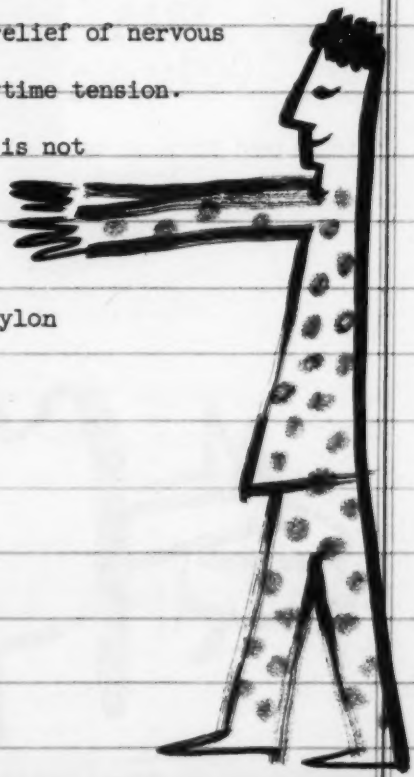
Johnson & Johnson

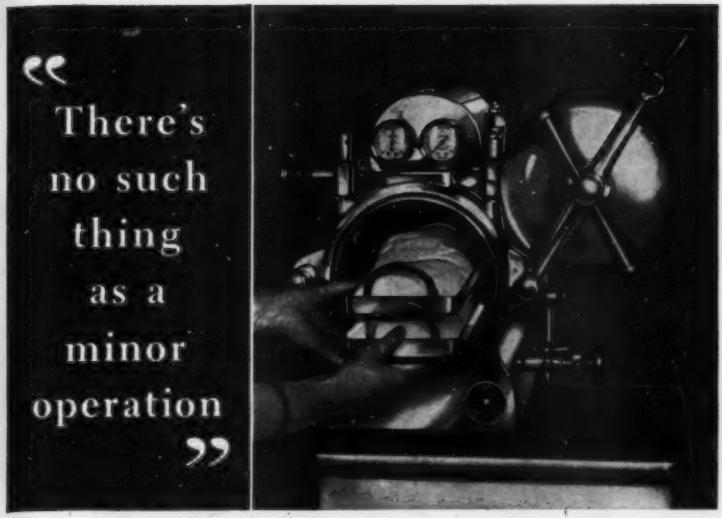
at ease... you may put your own mind at ease as well as calm your patient when you prescribe Noludar as a sedative (or in larger dosage as a hypnotic). There is little danger of habituation or other side effects because Noludar is not a barbiturate. Available in 50-mg and 200-mg tablets, and in liquid form, 50 mg per teaspoonful.

Rest comes best to the relaxed patient. Noludar relaxes the patient and usually induces sleep within one-half to one hour, lasting for 6 to 7 hours. Clinical studies in over 3,000 patients have confirmed the usefulness of Noludar in the relief of nervous insomnia and daytime tension.

Noludar 'Roche' is not a barbiturate.

Noludar™ -
brand of methyprylon





... said a famous authority on safety in operations. Any operation, he pointed out, is of major concern to the patient. Overlooking fundamental asepsis even in a simple case may result in a serious disability.

Protect yourself . . . your patients

Your patients have a right to expect thorough aseptic treatment in your office. *They are not getting it if you depend only on boiling water to "sterilize" instruments.* Too many sporulating bacteria survive boiling at 212° F. What is needed is moist heat of at least 250° F. And that calls for the certainty of autoclave sterilization.

A Pelton Autoclave brings to your office the safety *plus* the speed of hospital sterilization. Any one of the three Pelton models *sterilizes* fabrics, gloves and solutions as well as instruments. Each generates its own steam and stores it for immediate use.

See your dealer or write for literature describing Pelton Autoclaves.

Professional Equipment Since 1900

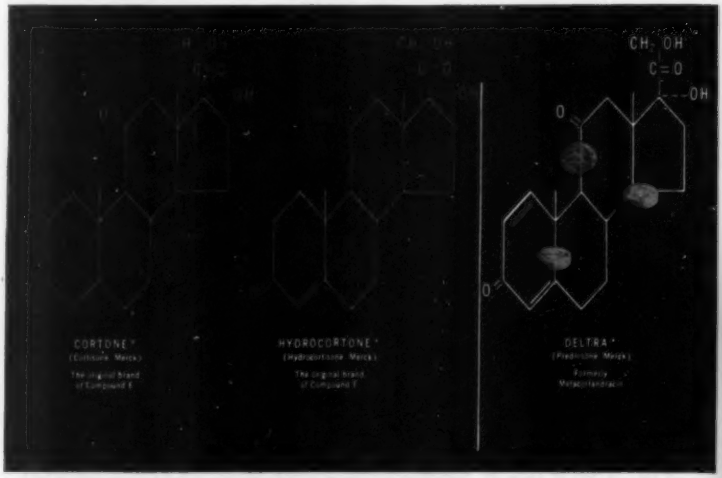
PELTON

THE PELTON & CRANE CO. • DETROIT 2, MICHIGAN

DELTRA® TABLETS

(PREDNISONE, MERCK)

(FORMERLY METACORTANDRACIN)



DELTRA is the Merck brand of the new steroid, prednisone

(FORMERLY METACORTANDRACIN)

DELTRA is a new synthetic analogue of cortisone. DELTRA produces anti-inflammatory effects similar to cortisone, but therapeutic response has been observed with considerably lower dosage. With DELTRA, favorable results have been reported in rheumatoid arthritis with an initial daily dosage of 20 to 30 mg. and a daily maintenance dose range between 5 and 20 mg.

Salt and water retention are less likely with recommended doses of DELTRA than with the higher doses of cortisone required for comparable therapeutic effect.

Indications for DELTRA: Rheumatoid arthritis, bronchial asthma, inflammatory skin conditions.

SUPPLIED: DELTRA is supplied as 5 mg. tablets (scored) in bottles of 30 and 100.

SHARP & DOHME

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DIVISION OF MERCK & CO., INC.

Ease of application

Transparency

Flexibility and

Minimal redressing

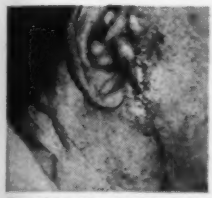
distinguish

AEROPLAST®

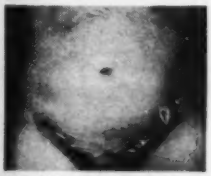
Brand of Vibesate

LIQUID SURGICAL DRESSING

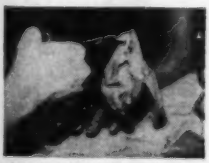
Sprayed directly onto the lesion from an aerosol "bomb," Aeroplast forms a protective plastic film dressing over any body contour. Aseptic lesions remain sterile as long as the dressings are intact. Aeroplast dressings are impermeable to bacteria. To remove, Aeroplast is simply peeled off.



Face laceration dressed with Aeroplast healed in four days.[2]



Bilateral inguinal hernia incisions protected by Aeroplast 4th post-operative day.[1]



Aeroplast dressing is peeled off like a glove 12 days after 2nd degree burn.[2]

Rigler and Adams[1] dressed 110 operative wounds (including thoracotomies, laparotomies, inguinal hernias and miscellaneous lesions) with Aeroplast. "A single application sufficed in all but fifteen cases. No instances of systemic or clear-cut reactions were observed. Satisfactory results, with no evidence of erythema, infection, or necrosis were obtained in the majority of cases."

In 39 miscellaneous wounds dressed with Aeroplast (including appendectomies, open reduction of fractures, skin graft donor sites, lacerations, excoriation), Choy[2] reports infection in only one case, which promptly cleared with redressing, and uneventful healing in all others.

1. Rigler, S. P. and Adams, W. E.: Experience with a new sprayable plastic as a dressing for operative wounds, Surg. 36:792 (Oct.) 1954. (University of Chicago Clinics, Chicago, Surgical Service).

2. Choy, D. S. J.: Clinical trials of a new plastic dressing for burns and surgical wounds, Arch. Surg. 68:33 (Jan.) 1954. (Bellevue Hospital, New York, Third Surgical Division—Dr. John Mulholland, chief).

Supplied in 6 oz. aerosol-type dispenser through your prescription pharmacy or surgical dealer.

For reprints and literature write to:

Aeroplast® CORPORATION

429 DELLROSE AVENUE, DAYTON 3, OHIO

IN THE PATIENT WHO FAILS

TO RESPOND TO SALICYLATES ALONE

Armyl® + F

IN THE PATIENT WHO NEEDS LONG-TERM

MANAGEMENT OF RESIDUAL

SYMPTOMS AFTER

ACTH THERAPY

Each Armyl + F capsulette contains:

Compound F (hydrocortisone-free alcohol)	2.0 mg.
Potassium Salicylate (5 grains)	0.30 Gm.
Potassium Para-aminobenzoate (5 grains)	0.30 Gm.
Ascorbic Acid	50.0 mg.

Bottles of 50 capsulettes

new product fills the therapeutic gap

in the therapy of "rheumatic" disease

Relieves Pain

Relieves Inflammation

Permits Increased Range of Motion

Armyl + F was formulated specifically for conditions which fail to respond satisfactorily to salicylates alone, and for the patient requiring long-term management of residual symptoms after ACTH therapy has successfully overcome the severe, acute stage. Thus Armyl + F has a well defined place in the treatment of rheumatic-arthritic disease represented by rheumatoid arthritis and spondylitis (mild forms) osteoarthritis (painful stage) rheumatic fever (subacute phase of mild degree) gout—subacute stage and interval gout, bursitis, myositis, tendinitis, synovitis, fibrositis, neuritis.

THE ARMOUR LABORATORIES

A DIVISION OF ARMOUR AND COMPANY • KANKAKEE, ILLINOIS

TRICHOMONAL

95.5% of patients were asymptomatic and no organisms were seen after one week and remained so for the three months of observation.*

MONILIAL

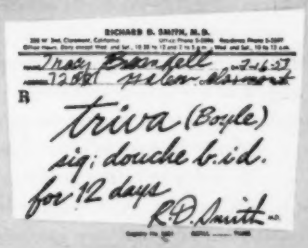
"Twelve patients (of 15) became asymptomatic and no organisms were seen after one week of treatment. Eleven remained so for the six weeks of observation."*

NON-SPECIFIC

Highly effective dependent on primary source. "23 cases of cervical erosion were treated. 13 of them were apparently cured."*

ADVANTAGES OF TRIVA

- **12-DAY TREATMENT (6 days for 95.5% of cases of Trichomonal)***
- **TREATS ALL 3 FORMS**
- **SIMPLE** For patient: a vaginal douche. A powder in accurate one-dose packets. For doctor: no arduous office treatments. No microscopic diagnosis. Only one preparation—no other medication.
- **SAFE** Non-toxic. Safely used during pregnancy.
- **CLEAN** A cleansing douche. No messy staining creams, inserts or insufflations.
- **EFFECTIVE IN ANY pH MEDIUM** Useful in pre- and post-operative, and post-partum care.



AVAILABLE AT ALL PHARMACIES in convenient packages of 24 individual 3 Gm. packets, each containing 35% Alkyl aryl sulfonate, .33% Disodium ethylene bisiminodiacetate, 53% Sodium sulfate, 2% Oxyquinoline sulfate and 9.67% dispersant.

BOYLE

BOYLE & COMPANY
LOS ANGELES 58, CALIFORNIA

*Gernand, H.C., and Gallagher, Robt.: Obst. & Gyn. 2:522 (Nov.) 1953

because feet must last a lifetime

. . . every step a child takes demands carefully planned protection . . . the kind of protection offered by all Stride Rite shoes, whether Firsties and toddler styles or styles for school or play or partying.

Stride Rites are skillfully crafted from top-quality leathers over proven lasts to give the accurate, shape-holding fit for which they are so famous. Finished workmanship, consistent high quality and long wear are a few of the many other reasons why most doctors who know Stride Rites recommend them.

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Specially packed for you—

Kleenex Tissues

in the WHITE box

Now Kleenex, the only tissue that pops up, serves just one at a time—comes in a new professional packing. The new white box is *designed especially* for physicians. And you can order Kleenex* Tissues in an easy-to-store case of 24 boxes. Keep Kleenex handy —for dozens of office uses.

Order through your supply dealer

*T. M. REG. U. S. PAT. OFF.

"I can still do a big wash every week and never mind it at all!"

Many a modern grandmother is a fair match for the younger members of her family. To help such persons sustain their activities as they grow older, dietary supplementation may be desirable. GEVRAL provides 14 vitamins, 11 minerals and purified intrinsic factor concentrate in one convenient capsule for geriatric use.

Gevral*

Geriatric Vitamin-Mineral Supplement Lederle

Each GEVRAL capsule contains:

Vitamin A	5000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Vitamin B_{12}	1 mcgm.
Thiamine Mononitrate (B_1)	5 mg.
Riboflavin (B_2)	5 mg.
Niacinamide	15 mg.
Folic Acid	1 mg.
Pyridoxine HCl (B_6)	0.5 mg.
Ca Pantothenate	5 mg.
Choline Dihydrogen Citrate	100 mg.
Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
Vitamin E (as tocopheryl acetates)	10 I. U.
Rutin	25 mg.
Purified Intrinsic Factor Concentrate	0.5 mg.
Iron (as $FeSO_4$)	10 mg.
Iodine (as KI)	0.5 mg.
Calcium (as $CaHPO_4$)	145 mg.
Phosphorus (as $CaHPO_4$)	110 mg.
Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF)	0.1 mg.
Manganese (as MnO_2)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K_2SO_4)	5 mg.
Zinc (as ZnO)	0.5 mg.

Other Lederle geriatric products include: GEVRABON* Vitamin-Mineral Supplement Liquid with a wine flavor; GEVRAL* Protein Vitamin-Mineral-Protein Supplement Powder; and GEVRINE* Vitamin-Mineral-Hormone Capsule.

Lederle LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U.S. PAT. OFF.

unexcelled among sulfa drugs

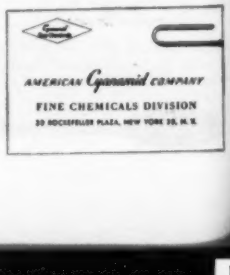
for highest potency • wide spectrum • highest blood, plasma & tissue levels • safety* • minimal side effects • economy

*Valid tests, clinical trials, and long use prove that the Triple Sulfas offer greater relative safety than any single sulfa, and that they compare favorably with any potent therapeutic agent in their relative freedom from toxic side effects. Besides their considerable safety, the Triple Sulfas are distinguished by their established efficacy, broad-spectrum activity, and outstanding economy. Their use increases daily.

Triple Sulfas, alone or in combination with certain other agents, are available from leading pharmaceutical manufacturers under their own brand names. This message is presented in their behalf.

All sulfas are not Triple Sulfas!

ASK ANY MEDICAL REPRESENTATIVE ABOUT THE TRIPLE SULFA PRODUCTS HIS COMPANY OFFERS



Editorials

Too few secretaries • What to look for in investments • It's the little things that count • Reduce the fee? • Insurance for the 'uninsurable'

Secretary Shortage

Perhaps you haven't noticed, but the secretary shortage is becoming acute. Remember the low birth rate of the depression years? Well, it's just now having its full effect. Today there are a million fewer young women between 19 and 24 than there were a decade ago. And more of them than ever are getting married, having children, giving up office work.

What does this mean to you as an employer? Well, it means that you've got to expect stiffer competition in bidding for scarce secretarial talent. Already, in some large cities, beginning secretaries are getting $70 a week. They're also being offered certain fringe benefits (e.g., pension plans) that you can't hope to duplicate.

If you've got a good girl now, how can you keep her? We'd suggest that you consider offering some fringe benefits of your own. The following, for example, have worked well in medical offices:

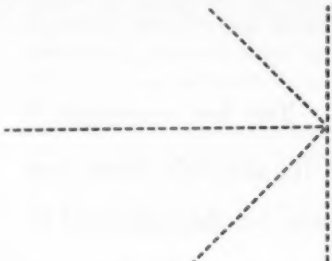
Overtime pay: A Detroit physician discovered that his employes were most likely to grumble about extra night work. He now pays time-and-a-quarter for evening hours; and the grumbling has ceased. Quite a few other medical offices use this same formula.

Sick leave with pay: A Cincinnati doctor allows his aides two weeks' absence for illness during the year. (Beyond two weeks, their pay stops.) And for every unused day of sick leave, they get a half-day's additional vacation time. Thus there's some incentive for not missing much work.

Optional holidays: A Manhattan M.D. observes all legal holidays—and allows his aide five extra holidays besides. She can take these on Columbus Day, Armistice Day, the Friday after Thanksgiving, or "whenever mutually convenient." They're in addition to the usual vacation with pay.

Year-end bonuses: Just before Christmas, a Chicago practitioner pays two weeks' extra salary to aides who have been with him throughout the year. Just before the New Year, another Chicago physician pays his secretary 1 per cent of his gross earn-

Areas of Clinical Study / One of a series



ANEMIA OF INFANCY

Recently completed—1954—studies [1, 2] again confirm the unique value of Roncovite (cobalt-iron) in the prevention and treatment of infant anemia.

Clinical results show that routine administration of Roncovite can completely prevent the iron deficiency which so frequently develops in the first six months of life.

RONCOVITE (*Cobalt-Iron*) *has introduced a wholly new concept in anti-anemia therapy. It is based upon the unique hemopoietic stimulation produced only by cobalt. The application of this new concept has led to marked, often dramatic, advances in the successful treatment of many of the anemias.*

EFFECTIVE

"It is a significant fact that none of the... cases receiving iron as well as cobalt required additional iron therapy and that the haemoglobin levels of this group remained consistently and significantly higher than those in any other group after the age of 4 months."[1]

"...there can be no doubt that the average hemoglobin values... are greater in the cobalt-iron (Roncovite) treated group."[1]

PATIENT SATISFACTION

"...the mothers of these anaemic infants frequently stated spontaneously that the children were much improved, with increased appetite and vigour. It seems possible, therefore, that even if anaemia in premature infants does not usually produce marked symptoms, there is a subclinical debility which becomes more evident in retrospect."[1]

SAFETY

"There was no evidence of toxicity in any case under treatment:...There is nothing to suggest that cobalt in any way impairs the general progress or rate of weight gain in premature infants in the dosage employed."[1]

"The babies were closely observed daily for ill effects of the medication while at the premature unit and when they returned for check ups. None of them showed harmful effects despite the large doses...A few of the babies ...have been followed for more than 100 days with no ill effects noted."[2]

SUPPLIED:

RONCOVITE DROPS

Each 0.6 cc. (10 drops) provides:
Cobalt chloride.....40 mg.
(Cobalt 9.9 mg.)
Ferrous sulfate.....75 mg.

RONCOVITE TABLETS

Each enteric coated, red tablet contains:
Cobalt chloride.....15 mg.
Ferrous sulfate exsiccated.....0.2 Gm.

RONCOVITE-OB

Each enteric coated, red capsule-shaped tablet contains:
Cobalt chloride.....15 mg.
Ferrous sulfate exsiccated.....0.2 Gm.
Calcium lactate.....0.9 Gm.
Vitamin D.....250 units

DOSAGE:

One tablet after each meal and at bedtime. In children one year or older 0.6 cc. (10 drops); infants less than one year 0.3 cc. (5 drops): once daily diluted with water, milk, fruit or vegetable juice.

1. Coles, B. L., and James, U.: Arch. of Disease in Childhood *29*:85 (1954).
2. Quilligan, J. J., Jr.: Texas State J. Med. *50*:294 (May) 1954.

Bibliography of 192 references available on request.

RONCOVITE

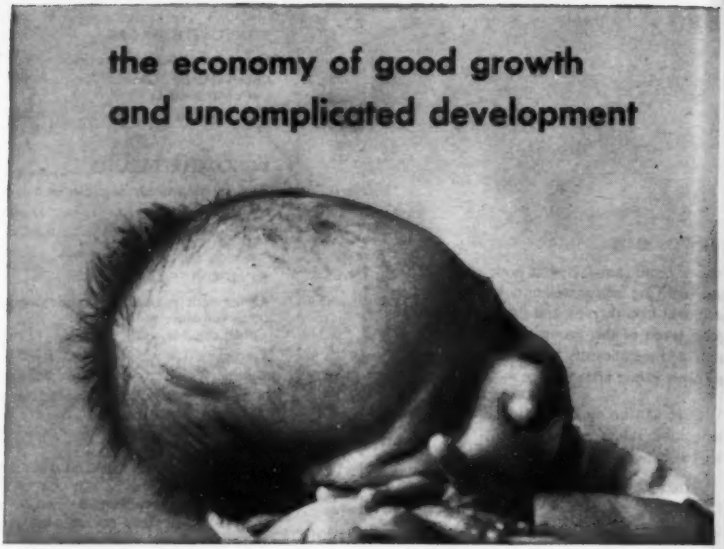
The original, clinically proved cobalt-iron product.

LLOYD

BROTHERS, INC.

Cincinnati, Ohio

In the Service of Medicine Since 1870



SIMILAC POWDER—*physiologic food during the first year of life*—

To assure sound growth and reduce many of the complications commonly encountered in the first year of life, the full, balanced Similac formula provides: fat, protein and carbohydrate closely approximating the content of human breast milk in quality and quantity; a full complement of known essential vitamins in adequate amounts; an adjusted mineral content; a soft, fluid curd with zero tension, assuring rapid and easy digestion.

SIMILAC POWDER—*stable in price . . . an economy in feeding*—

With food costs at or near an all-time high, the price of Similac has remained relatively constant since 1923. Similac with its complete modification and added vitamins is virtually the same in price as vitamin-supplemented whole-milk feeding—and in many instances actually affords greater economy.

SIMILAC *powder*

There is no closer equivalent to the milk of healthy, well-nourished mothers

SUPPLIED: Tins of 1 lb., with measuring cup. Similac is also available as concentrated Liquid in tins of 13 fl. oz.

M & R LABORATORIES, *Columbus 16, Ohio*

ings for the year. Both men have found such bonuses a great stabilizing influence.

The greatest stabilizing influence, of course, is a respectable basic salary. Not many doctors can compete with industry on this score. But they can at least come close enough so that special benefits will make up the difference.

Free medical care is one such benefit. (Even for major medical services, 85 per cent of doctors charge their aides nothing at all, according to a past MEDICAL ECONOMICS survey.) But free medical care, by itself, may no longer be enough of a lure.

If that's getting to be the case in your area, better think about the fringe benefits mentioned here. They're tax-deductible and not too costly. In fact, they're just about the cheapest insurance you can buy against the secretary shortage.

Investment Aims

"I've put my savings in some nice, steady securities that pay me around 6 per cent," a colleague we've known a long time told us recently. He seemed surprised when we asked him why.

"What do you mean, *why?*" he retorted. "Do you know any better way to get good current income?"

We pointed out that he didn't

need more current income; he had a good income already from his practice. And we quoted him something that Dr. T. Kenneth Callister wrote in our pages a couple of months ago:

"What good . . . is a 6 per cent dividend on a security if the security declines 6 per cent in value or if it continues to be worth the same number of dollars but the value of the dollar declines 6 per cent? There's only one answer; and that's to invest for capital appreciation, not for dividends or interest . . ."

This advice may not fit every doctor's situation, but it fitted our friend's to a T. Though current income wasn't a problem for him, retirement income *was*. He needed to build up his investment capital.

He could do it by picking growth stocks, by aiming for capital gains, by forgetting about high dividends. That way he'd have the money when he needed it. And he'd pay lower taxes on it.

Little Things

If you can speak Spanish—or German, or Italian, or even Urdu—the Essex County (N.J.) Medical Society will put you on its list of polyglot practitioners. Every so often, the society gets a call for a doctor who can speak a specific foreign language. Such a list is a real boon

Overlooking Hydromassage?

Are you aware that your patients with circulatory, muscular, bone and nervous disorders may now obtain the benefits of whirlpool hydromassage in the bathtub at home . . . and at reasonable cost?

HEAT PLUS MASSAGE

As you know, rehabilitation centers have used whirlpool therapy for years because of its unique ability to provide penetrating heat simultaneously with mild massage to stimulate circulation. Unfortunately, its use has been greatly restricted because of the high cost for the equipment and its installation.

NOW A BATHTUB UNIT

The new portable Jacuzzi — which has the same powerful action as conventional tank-mounted units—needs no special tank or plumbing. Consequently, cost is greatly reduced; and you can now prescribe whirlpool therapy for patients at home. The Jacuzzi is made by one of the nation's foremost manufacturers of pumping equipment. It has been developed through seven years of research under supervision of physicians and is unconditionally approved for professional use by Underwriters Laboratories and Canadian Standards Association.

Jacuzzi HYDROMASSAGE

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Hydrotherapy Division
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to one segment of the local population, to say nothing of the foreign-speaking physicians.

Does your community have foreign-speaking elements? Could it use such a list? If so, remember:

Public relations is a lot of little things.

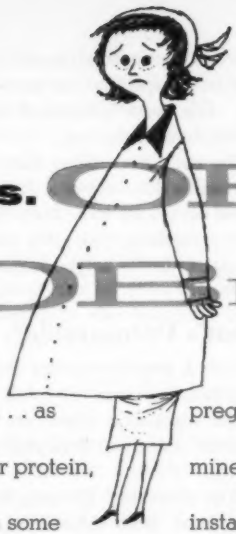
Disputed Fees

An internist we know usually sends a bill of $75 for a complete cardiovascular survey. And sometimes the patient waxes wroth because he can't see why a "purely medical" procedure should command such fees when, for only a few dollars more, he could have had something as dramatic as abdominal surgery. So he asks for an adjustment.

To most of us, this presents a familiar dilemma. Suppose you *do* reduce the fee. That's bad because it looks as if you overcharged in the first place. Suppose you *don't* reduce the fee. That's bad because it makes you look inhuman and intransigent.

Our internist-friend gets around this dilemma rather neatly. He listens to the irate citizen. Then he says in a calm and friendly voice:

"I know just how you feel. Well, I had to test for prothrombin. And for color index. I determined blood sugar. And cholesterol. I had to do these tests and interpret them. I



Mrs. OB needs an OBRON buildup

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OBron supplies iron and calcium plus eight other minerals, eight essential vitamins.

The OBron Buildup: A basic nutritional buildup for your OB patients, one to three capsules daily. Bottles of 30 and 100 soft, soluble capsules.

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Dicalcium Phosphate Anhydrous*	770 mg.
Ferrous Sulfate Dried, U.S.P.	44 mg.
Vitamin A (Palmitate)	5,000 U.S.P. Units
Vitamin D (Irradiated Ergosterol)	400 U.S.P. Units
Thiamine Hydrochloride, U.S.P.	2 mg.
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Pyridoxine Hydrochloride, U.S.P.	0.5 mg.
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Niacinamide	20 mg.
Calcium Pantothenate	3 mg.
Cobalt (from Cobaltous Sulfate)	0.033 mg.
Copper (from Cupric Sulfate)	0.33 mg.
Iodine (from Potassium Iodide)	0.05 mg.
Manganese (from Manganese Sulfate)	0.33 mg.
Magnesium (from Magnesium Sulfate)	1 mg.
Molybdenum (from Sodium Molybdate)	0.07 mg.
Potassium (from Potassium Sulfate)	1.7 mg.
Zinc (from Zinc Sulfate)	0.4 mg.

*Equivalent to 975 mg. Dicalcium Phosphate Dihydrate.

POERIC Rx CHICAGO 11, ILLINOIS

1. Burke, B. S. and Stuart, H. C.: Nutrition requirements during pregnancy and lactation. J.A.M.A. 132:119 (May 8) 1946.

took an electrocardiogram, developed it, and interpreted it. I examined your chest under a fluoroscope, then took an X-ray picture, then developed that, then interpreted it . . .

"Now, I don't want you to feel that I've overcharged you. You've heard what was done. Tell me what *you* think a fair fee would be."

According to our informant, six patients out of ten look a bit sheepish and decide to pay the original amount. Three out of ten set the fee slightly lower than the original. Only one out of ten sets the fee extremely low. Our friend handles that one case by saying, still with grave friendliness:

"If you feel that you can't pay more than a nominal amount, I'll be glad to accept that as payment in full. I'm more interested in your health than in the fee."

The net? Something like 90 per cent collections from a group that would otherwise have been difficult. And something like 100 per cent salvage in terms of goodwill.

What's Uninsurable?

There's a popular notion that most conditions not now covered by our health insurance plans are "uninsurable." We don't believe it for one minute.

Why don't we? Because from the very start Blue Shield and Blue

Cross have covered conditions that, until they *were* covered, had always been considered "uninsurable."

Childbirth is a good example. Its incidence is high among young married couples; in fact, it's almost certain to occur. The insurance industry never used to regard it as an insurable risk. Then Blue Shield and Blue Cross moved into the field—and eventually the insurance companies followed suit.

Today you sometimes hear that word "uninsurable" applied to other things. Before you accept this casual verdict, better listen to some expert opinion. For example:

People over 65? "There's no good reason for not enrolling them," Dr. Charles G. Hayden, director of Massachusetts Medical Service, has said.

Prolonged illness? "The cost of physicians' services [in such cases] can be covered completely or almost completely by Blue Shield plans through a simple extension of benefits," according to Dr. Hayden.

Home and office calls? "Such services seem to be insurable, provided the subscriber assumes the cost of . . . the first few calls in any illness," the A.M.A.'s George Cooley has testified.

The big need in health insurance today is more adequate coverage. Let's not be diverted from this goal by loose use of the word "uninsurable." —H. SHERIDAN BAKETEL, M.D.

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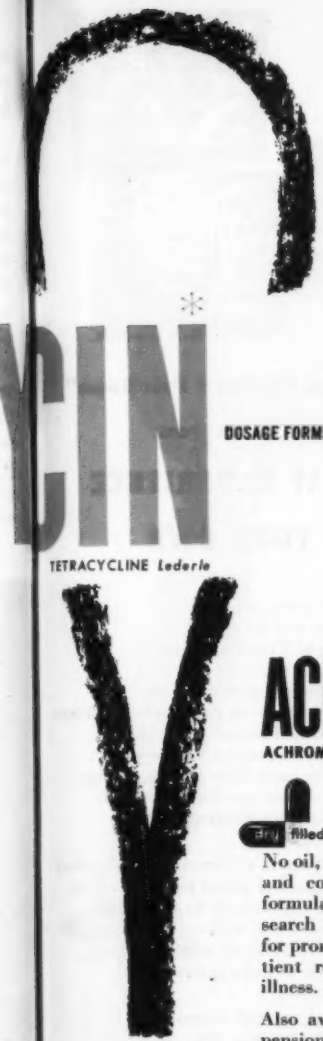
—produced under rigid quality control in Lederle's *own* laboratories



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SANBORN COMPANY, or any of its representatives, will be glad to furnish you with a list of Viso-Cardiette owners in your city, or area, so that you may ask *them* about their experiences with the Viso. We also invite you to ask us for completely descriptive literature on the Viso. And, if you are located in one of the thirty Sanborn Branch Office or Service Agency cities, or its environs, a representative will be more than glad to arrange a demonstration in your office. These are the customarily available aids in selecting an electrocardiograph, not necessarily exclusive to Sanborn.

However, exclusive *with* Sanborn is a "direct-to-user" policy which offers any physician or hospital added benefits in ECG ownership. Among these is the opportunity to use a Viso Cardiette *as your own,* for 15 days, and without obligation of any kind. (If, at the end of the test period, you don't like the Viso, you simply return it to us in its convenient, specially designed shipping carton.)

Thus, to the usual aids in judging and selecting an ECG, Sanborn lets you add *your own experience.* May we tell you more about this plan?

Also offered under this plan is the Sanborn METABULATOR, a metabolism tester with many conveniences. Descriptive literature is available.

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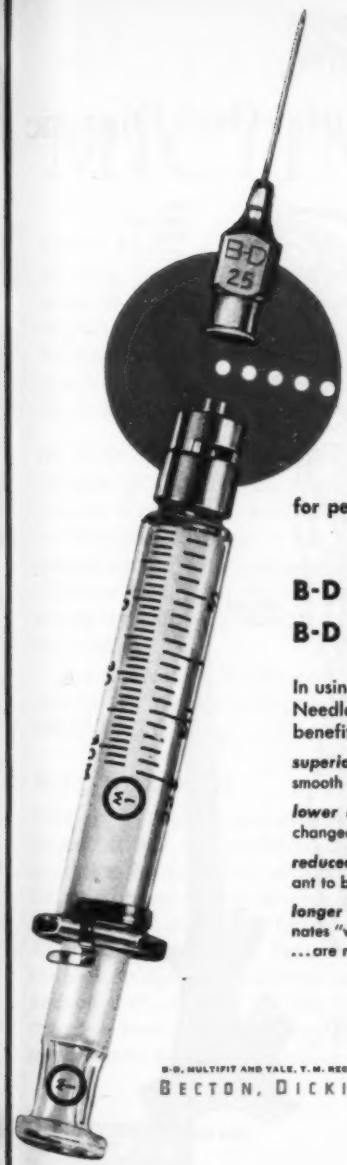

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superior performance—no leaking or jamming, uniformly smooth operation, minimum discomfort for your patients

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longer life—unground, clear glass barrel virtually eliminates "wear-out" due to friction; needles hold a sharp point ...are made to withstand rugged use.

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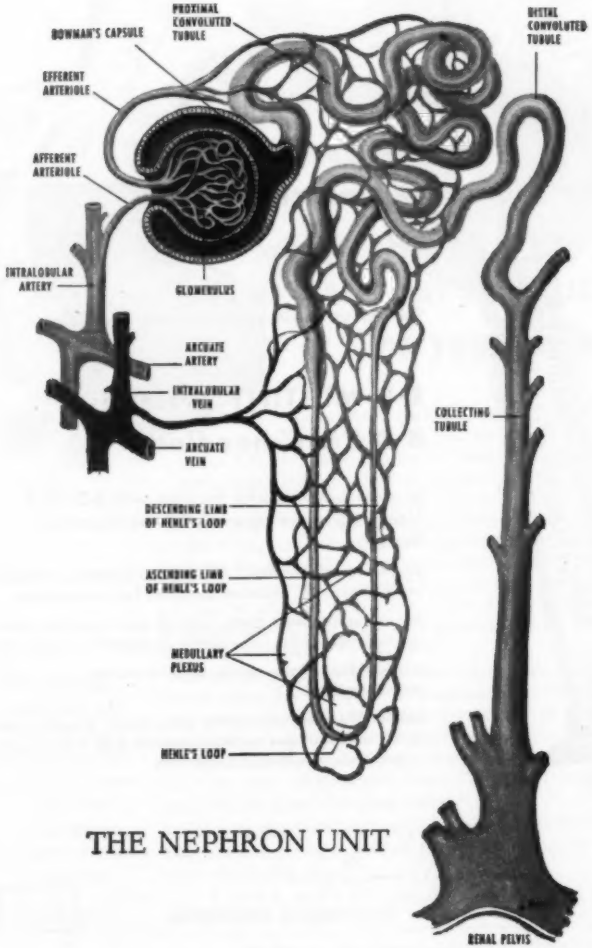

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A *NEW* PRODUCT OF SEARLE RESEARCH

MICTINE*

STRUCTURE

Mictine, brand of aminometramide, is 1-allyl-3-ethyl-6-aminotetrahydropyrimidinedione. Mictine—result of years of research—*is not* a mercurial, xanthine or sulfonamide agent.

ACTION AND EFFECTIVENESS

Mictine inhibits reabsorption of sodium ions by the renal tubule. In therapeutic dosage it has not caused any effect on glomerular filtration rate, renal plasma flow, cardiac output, heart rate or blood pressure.

Approximately 70 per cent of unselected patients respond to Mictine.

WELL-TOLERATED

Mictine is without known toxic effects. It has not produced any alteration in the blood or blood-forming organs or any adverse effects in renal or hepatic function. At times headache or gastrointestinal symptoms (anorexia or nausea but rarely vomiting or diarrhea) have occurred; however, these effects may be reduced to a minimum by giving Mictine on an interrupted dosage schedule.

ADMINISTRATION

Mictine is useful primarily in the *maintenance* of an edema-free state and in the *initial and continuing* control of patients in mild congestive failure. In such patients, dosage is one to four tablets daily *with meals*, in divided doses on an interrupted schedule. An interrupted dosage schedule may be accomplished by giving the drug on alternate days; or by its administration for three consecutive days and its omission for four consecutive days.

Mictine also may be used for *initial* diuresis in *more severe* congestive states, particularly when mercurial diuretics are contraindicated. In these more severe congestive states, dosage is four to six tablets daily *with meals*, in divided doses on an interrupted schedule similar to those mentioned above.

SUPPLIED

Bottles of 100 uncoated tablets of 200 mg. each.

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Using CORTRIL Vaginal Tablets as supportive therapy in conjunction with usual measures, 18 investigators* treated monilial, trichomonal, senile, allergic, and nonspecific vaginitis. They obtained a good to excellent response in 90 per cent of patients.

CORTRIL, by virtue of its anti-inflammatory action, reduces local edema and inflammation in vaginitis. The resultant relief from vulvovaginal itching and discharge is often obtained within minutes or hours, as contrasted with two to three days with ordinary measures.

administration: Insertion of 1 or 2 tablets daily. **supplied:** 10 mg. tablets.

Personal communications

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What Hospital Administrators Say About Doctors

Here's why the administrator's 'profound regard' for the M.D. is tempered by resentment. But this tells only one side of the story. What's your view?

By Robert M. Cunningham Jr.

● A few months ago, doctors in one Midwestern state found anonymous postcards in their morning mail. On the postcards, a crude cartoon depicted a powerful, leering hospital administrator turning thumbs down on physicians. "After we get the specialists under control," he was represented as saying, "we can start charging the G.P.s for use of the hospital."

This amateur work of art was circulated to the membership list of the state medical society. It reflected a view of hospital administrators that many doctors have expressed in recent years.

Was there some truth in it? Do administrators actually think hospitals should run the practice of medicine? Do

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MR. CUNNINGHAM *is editor of The Modern Hospital.*

they really consider the staff physician just another source of revenue, like a Government bond?

Recently I've had long, serious talks with a number of hospital administrators—talks aimed at finding out their real feelings about medical men. As a result of these interviews, and of eighteen years' close association with both doctors and administrators, I can make the following categorical statements:

¶ There is no foundation whatever for the allegation that hospital administrators want to control the practice of medicine.

¶ Most hospital administrators have a profound regard for physicians as human beings of high purpose.

¶ But many sore spots are produced by the constant rubbing of medical prerogative against administrative responsibility.

Calculated Risk

This article is about the sore spots. In writing it, I risk being misinterpreted; I risk leaving the impression that most administrators think most doctors are heels.

Of course that isn't so. The doctor who is devoted and honest and modest has the sincere admiration of the hospital administrator. And most administrators are wise enough to understand that doctors, like everybody else, are complex and changeable; that sometimes they behave admirably and sometimes they don't.

But like the M.D. who's more interested in pathological than in normal tissue, I have naturally searched out the complaints rather than the praise. I want to make it clear that I don't pretend, in what follows, to speak for a majority of hospital administrators or for any official association. This is my own estimate of the truth, based only on my own observations.

Here, then, are some of the sore spots, as seen from the administrative side:

Too Much Pride?

1. *The doctor is an occupational snob.*

Buried deep within the administrator's answers to questions about his medical staff is a natural resentment of the professional snobbishness of doctors. The more thoughtful administrators are even willing to bring it into the open.

"Of course," one of them said to me, "there are men and women in *every* field who think all other occupations beneath theirs. Certainly we have such people in hospital administration. A man wouldn't be much good if he didn't take pride in his work; and it's probably natural for doctors to believe that medicine is the most important thing in the world.

"Even so, it's hard to swallow the M.D.'s everlasting assumption of superiority. For example, I wouldn't dream of calling on a doctor without an appointment; but most of the doctors on my staff assume they can

come into my office at any time of the day or night to talk about their problems, however trivial.

"Now, I'm always glad to see our doctors, and I want them to feel free to talk to me. But I have important work, and appointments, too. I'd appreciate some recognition of this on the part of doctors."

Just Dropping In

A little thing? Perhaps. But several of the administrators I talked with mentioned it. In every case, the resentment arose not from the doctors' practice of "dropping in," but from their evident assumption that the administrator had nothing else to do.

"I went without lunch nearly every day for ten years, so I'd be in my office when the surgeons came down from the operating-room floor," one man told me. "That's when they liked to come in. We got along fine. In fact, I couldn't have done my job without those informal talks. But do you know, it never once occurred to one of those surgeons that the noon hour might not be a convenient time for me!"

A kindred complaint concerns the way doctors use the word "layman," with its implication of inferiority. "I happen to be a certified public accountant," an administrator told me. "I don't know the names of the long muscles—but the doctors can't make up a balance sheet, either. I'm aware that medical care, and not the balance sheet, is the important thing in the hospital. But I'm proud of *my* occupation, too; and I dislike being treated as part of the equipment, like a sphygmomanometer."

Doctor's Yardstick

It has been my own observation (which the administrators themselves confirmed) that the biggest doctors are the least snobbish. The chiefs of service at the best hospitals, the A.M.A. presidents, the regents of the American College of Surgeons, and men of like stature are the least likely to act indifferently toward their nonmedical associates.

"The American medical profession has at its disposal the services of hundreds of lay people who are just as dedicated to the cause of medicine as the doctors are," Dr. Elmer Hess told an A.M.A. conference last year. "They come to us as partners striving to achieve perfection in our service to humanity. We are wise when we follow their counsel; we are foolish when we choose to ignore it."

Holier Than Who?

2. *Too many doctors are moral hypocrites.*

The hospital administrator has a unique chance to know which doctors on the staff are strictly ethical and which aren't. If there's widespread fee splitting, he's aware of it. If some surgeons are performing unjustified operations, he knows that, too. And he has a pretty good idea

of how well his staff doctors follow the first Principle of Medical Ethics: "The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration."

Where medical men fall short of meeting this ideal, most administrators avoid passing moral judgment. But one thing rankles: the deficient doctor's pretensions to nobility.

Medicine's Morals

"I can understand why, under economic pressure, some men split fees," one administrator said to me. "And I don't particularly blame doctors who charge all they can get. After all, isn't that what most of us do? What I detest is the 'holier-than-thou' attitude of even the wrongdoers themselves. They act as if a medical degree automatically assured moral sanctity."

This practice of equating an M.D. and a halo is apparently responsible for the profession's hypersensitivity to outside criticism. A number of administrators cited the angry reaction of staff physicians to articles that have appeared in the lay press lately, exposing such evils as fee splitting and unnecessary operations.

" Invariably, the doctors call these articles smears," one man commented. "It never seems to occur to them that they might be true. If doctors were a little more critical of *themselves*, maybe such articles wouldn't need to be written!"

As an illustration of this lack of self-criticism, the administrator of a suburban hospital told me the following story:

"When I came here about five years ago, I soon learned that one doctor on the staff was definitely out of line. He was habitually behind with his records. He violated staff rules about consultations. Even his surgical results were questionable.

"In discussing the problem with the president of the staff, I asked whether the staff had investigated these things. He said they hadn't. But he acknowledged they should.

"A few weeks later, I asked him if he'd had a chance to look into the matter. Again, he agreed that something should be done. The executive committee, he explained, just hadn't had time to go into it.

Odd Man Out

"Believe it or not, this went on for a whole year. After every executive-committee meeting, I checked to see whether the problem had been discussed. Invariably, for some reason, it hadn't been. Finally the hospital's board of trustees decided to act independently. The offending doctor wasn't reappointed to his staff position.

"Maybe you can guess what happened then: The entire medical staff, *including the president*, accused us of interfering in professional matters. The situation got so bad that townspeople were soon repeating the gossip that we were 'telling doctors how to practice medicine.'"

I don't know a single hospital administrator, or a single hospital trustee, who wants to tell doctors "how to practice medicine." I don't know a single administrator or trustee who hasn't wished with all his heart that the doctors *themselves* would take action against bad medical practices.

But I do know many administrators and trustees who believe they have some responsibility for what happens in their hospitals, and thus feel duty-bound to act in cases where the doctors won't.

There's still a section in the Principles of Medical Ethics that says: "A physician should expose, without fear or favor, incompetent or . . . unethical conduct on the part of members of the profession." But, as most hospital administrators see it, these are hollow words.

How widespread is "incompetent or unethical conduct" on the part of U.S. physicians? Nobody knows, of course. My own opinion, as a reporter in this field, is that there is more "bad medicine" than most good doctors like to think.

A member of the field staff of one of the organizations represented on the Joint Commission on Accreditation of Hospitals reported recently that he had investigated eighty-nine cases of alleged fee splitting, unjustified operations, and other ethical violations last year. "In how many cases did you find substantiating evidence?" he was asked.

"Eighty-nine," he replied.

3. *Doctors cross lines of management authority.*

Everybody understands that there must be two lines of authority in the hospital: administrative and professional. Along the line of professional care, no administrator challenges the doctor's authority. But too often, the physician tries to carry over his authority into decisions that should be largely administrative.

Whose Decision?

Said one typical administrator: "I would never question a doctor's authority to give orders to a nurse, supervisor, orderly, or anybody else in the hospital, in any matter concerning patient care. But I'm less certain of the staff doctor's right to have his particular brand of antibiotic, say, when our pharmacy carries the exact thing under another brand name. And is the surgeon within his rights when he insists on a particular needle, even though the surgical standards committee—composed of his colleagues on the surgical staff—has settled on another kind that's practically identical?"

Doctors who stand on professional privilege in connection with purchases and other administrative responsibilities are a recurring headache to the man who has to balance the budget. When management must bow to the whim of every staff physician, economy goes out the window—and the administrator may follow shortly.

There's no magic formula for solv-

ing all problems of divided authority. But the best results have been achieved in hospitals where the staff is consulted systematically in connection with administrative decisions having professional interest, and where the staff regulates its own administrative practices through organized committees. (The complaint of the doctor who *must* have his way is likely to be softened if it reaches the administrator's office via a committee of his professional colleagues.)

'They Bite the Hand . . .'

4. *Doctors tend to disparage their free workshop.*

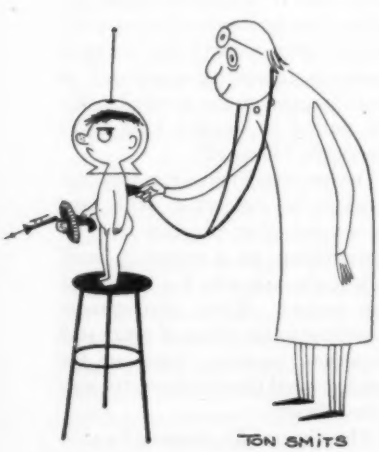
The doctor is probably the only person in our society who is given a completely staffed and fully equipped shop in which to conduct his own business for his own profit. Yet instead of appreciating this privilege, he takes it for granted. In many cases, he publicly criticizes the management without knowing what he's talking about.

Few doctors, for example, are competent to discuss hospital costs. They aren't informed, as the administrator must be, about prevailing wages and availability of essential personnel.

Except in their own limited fields, they don't know the cost of buying and operating hospital equipment. They can't follow daily food and fuel cost variations, as the administrator must.

Even so, many of them feel free, in talking with patients, to criticize the high costs of hospital care.

"This really hurts," an administrator told me sadly. "We spend a lot of time and effort explaining to the community why hospital care is worth what it costs. But how persuasive can we be without the doctor's support? After all, the patient figures his doctor knows *everything* about the hospital."



Who Runs Up Costs?

The worst of it, according to a number of administrators, is that the physicians themselves contribute more than anybody else to the high cost of hospital care.

"I suppose we could always save a few cents a day through improved management," said one administra-

tor. "But I'll tell you what *really* runs up the cost of hospital care: It's things like excessive use of laboratory and X-ray examinations; medications that aren't discontinued promptly when the need ends; and patients who, for the doctor's convenience, are admitted a day earlier than they ought to be, and discharged a day later."

The extent to which such practices add to costs is apparent in the studies made by Dr. Harry Becker for the Michigan State Medical Society and Michigan Blue Cross. These studies revealed that about 18 per cent of the Blue Cross premium went down the drain in the form of payment for unnecessary service. Published reports of the study carefully pointed out that the blame for such waste must be divided among doctors, hospitals, patients, and Blue Cross. But the nature of the services listed in the study made it clear that the *major* responsibility lay with the medical men.

Center of Interest

Then, too, most administrators reject the concept that the hospital exists chiefly as a workshop for doctors. They like to think the *patient* should be the center of interest.

"We can't have it both ways," said one administrator who is particularly concerned about public relations problems. "In hospitals where the convenience of the doctor must be served at all costs, the patient quickly gets to feel he doesn't count. We wake him up at dawn, to clear the way for the early morning surgical schedule; we let his meal cool at the end of the hall if a doctor is making rounds. All day long, in a dozen other ways, we indicate that it's the doctor, not the patient, who counts most.

"Years ago, when the average hospital patient was in a big ward—and probably paid little or nothing for his hospital care—this didn't make so much difference. The patient expected nothing; he was grateful for any little attention. But now, when patients are paying $20 a day, they resent being pushed around. And I don't blame them."

'Doctor's Orders'

5. *The doctor is an autocrat.*

The patient isn't the only thing in the hospital that has changed. Older methods of getting things done are being replaced by modern business methods. The hospital administrator still gives orders, of course. But like other business executives, he's apt to call a meeting of department heads first, to hear their opinions on the subject at issue.

There has been no parallel change in medicine. And there can't be. When the doctor gives an order, there's no time for a committee meeting to discuss it. Medicine has to be authoritarian through life-and-death necessity; and it isn't going to change.

But therein lies the basic cause of conflict in hospitals. [MORE ON 252]

This Office Can G-r-o-w

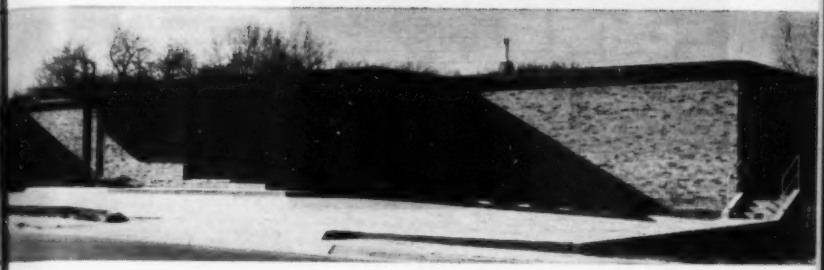
By Lois Hoffman

• It's not unusual for a doctor to move from rented quarters to a building of his own because he needs more office and parking space. But he sometimes overlooks the strong possibility that his practice may grow at an even faster rate than before, once he's in his new quarters. Result: In a few years he may again find himself cramped for space.

Four Omaha doctors who avoided making such a mistake are General Practitioners Clinton C. Millett and Leo V. Hughes and Internists Charles M. Root and Donald J. Bucholz. When they decided to move from their crowded downtown suite, they were determined to have enough elbowroom—not only for their present needs, but for all future needs as well.

Soon after they'd started working on plans for a new building with their architects, the Leo A. Daly Company, they were joined by four other men: Radiologist E. Stanley Pederson, Pediatricians Paul N. Morrow and Gerald C. O'Neill, and Psychiatrist R. Hugh Dickinson. In October, 1952, the eight doctors opened the doors of their Physicians' Building on Dodge Street, two miles from Omaha's business district.

Two more M.D.s joined them later, thus filling the original structure to capacity. And the owners were con-



EXPANDABLE OFFICE BUILDING has almost no windows. Besides keeping out noise and dirt, the solid brick walls were about 5 per cent cheaper to build, say the owners; and they save an estimated 20 per cent a year on heating and air-conditioning bills. Electricity cost? Not much higher than normal, the doctors believe. They contend that in most medical offices daylight alone is rarely adequate anyway.

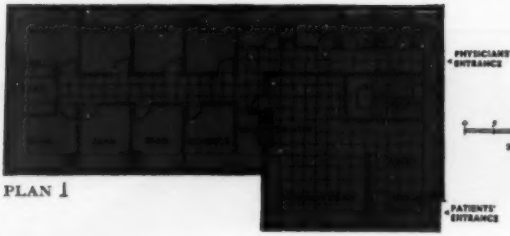
vinced they'd have little trouble finding occupants for additional suites if they made them available.

Fortunately, in blueprinting the structure they'd asked the architects to lay out a floor plan that could be expanded at will, with a minimum of trouble and expense. So last spring the doctors put up an addition as large as the original structure. Thus, their ten-man building has now become a twenty-man building.

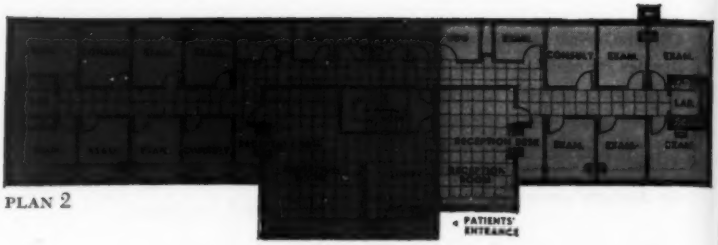
In many ways, their experience could serve as a model for others. Four principal lessons for doctors with a similar planning problem emerge from the Omaha physicians' story:

1. *Buy a large enough lot.* The Omaha men made sure they would have plenty of room for expansion, when the time came. [MORE TEXT ON 109]

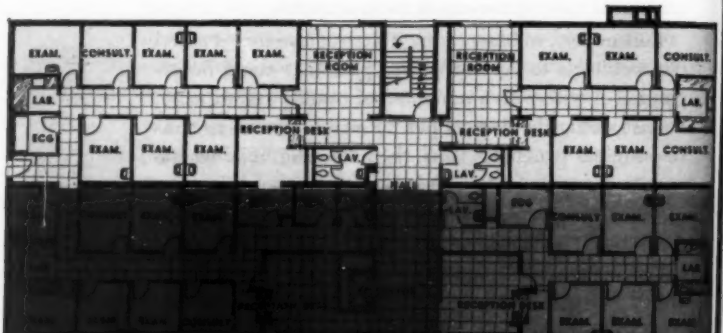
THIS OFFICE CAN GROW



PLAN 1



PLAN 2



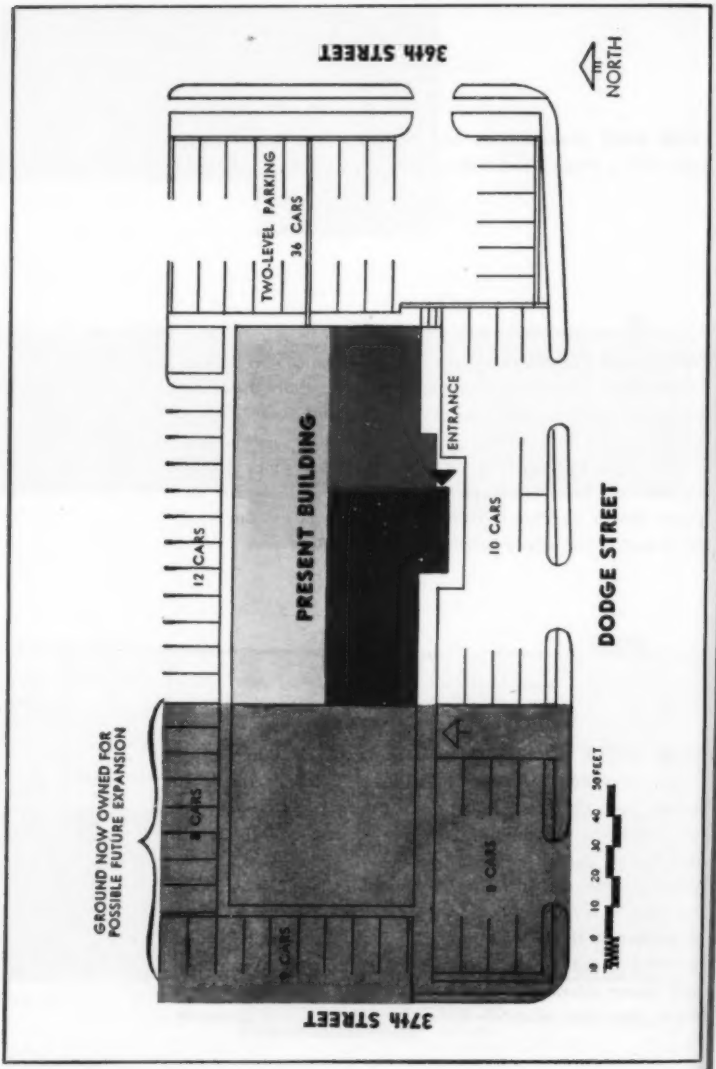
PLAN 3

◀ **BASIC UNIT** is a complete and efficient set-up for perhaps three M.D.s. Plans 2 and 3 show how units can be combined.

◀ **TWO UNITS COMBINED** make up the original main floor of the Physicians' Building. These units are essentially the same, though the medium blue unit at right is slightly smaller than the basic unit. In planning an expandable office, it's important to frame openings for their final purpose. Thus, if only one unit had been constructed originally, the physicians' entrance shown on Plan 1 could easily have been converted into a part of the upper corridor, as in Plan 2.

◀ **FOUR UNITS COMBINED** form the expanded main floor (with the addition shaded light blue). Three doctors now occupy each unit on this floor. A central, front-to-back corridor takes the traffic flow from the main entrance (which is used by all patients) to the rear part of the building. To make space for this corridor, an elevator replaced the original stairway, a lavatory was shifted, and the closet came out altogether. In the left wing there's now a narrow hall, formed in part by a walled-off portion of one examining room. Since such minor alterations were anticipated in the original blueprints, they cost relatively little.

[MORE ▶


36th STREET
NORTH
TWO-LEVEL PARKING
36 CARS
ENTRANCE
PRESENT BUILDING
12 CARS
10 CARS
DODGE STREET
GROUND NOW OWNED FOR POSSIBLE FUTURE EXPANSION
8 CARS
8 CARS
8 CARS
0 10 20 30 40 50 FEET
37th STREET

2. *Use a unit-type floor plan.* The architects of the Physicians' Building laid out a basic, self-contained unit that includes a waiting room, a receptionist's station, two consultation rooms, six examining rooms, a laboratory, a lobby, lavatories, and three small work and storage rooms (see Plan 1). Such a unit can accommodate as many as three or four physicians, say the Omaha M.D.s.

3. *Standardize treatment and consultation rooms.* With few exceptions, such rooms in the Omaha building have identical equipment and are identically laid out. Incidentally, the consultation rooms here are used for telephoning, for dictating correspondence, and for visits with detail men and others; practically all interviewing of patients is done in the treatment rooms.

4. *Plan for horizontal rather than vertical expansion.* Putting up a small building that can accommodate a second or third story later, say the architects, is often a waste of money. A vertically expandable structure, they point out, calls for much heavier and more expensive roof and wall construction. Then, if the original building proves large enough, the added cost of this construction is a total loss.

Following this advice, the owners of the Physicians' Building bought extra land instead of extra-heavy wall and roof construction. (Such land can usually be sold if it isn't needed.)

Built on a Hill

The lot occupied by the Physicians' Building slopes down sharply from the Dodge Street level. This slope—which might well have been a liability—actually helped keep excavation and earth-moving costs down.

In planning the building, the architects simply included as many basic units as were needed to accommodate the number of physicians who would be tenants. The units are not identical; but they are similar. For example:

The original part of the building was to house ten practitioners; so the architects arranged for two units on the street floor and two on the ground floor below. One lobby and two lavatories per story seemed sufficient; for that reason, these rooms (as well as one consultation room) were omitted from the second unit on each floor (see Plan 2).

Other variations, too, were necessary in planning the ground floor, which is big enough to accommodate three physicians, including a

◀ **PLOT PLAN** shows the original building, the addition, and the site of a possible annex. The owners believe that the planned parking space for a total of eighty-odd cars will be sufficient, since their office hours vary.

radiologist: The latter's quarters include a darkroom, a viewing room, a large laboratory, and two oversized rooms for X-ray equipment.

Two internists, two G.P.s, two pediatricians, and a psychiatrist were able to work comfortably on the original street floor.

When the building was enlarged, two more units were added on each floor, making a grand total of eight units (see Plan 3).

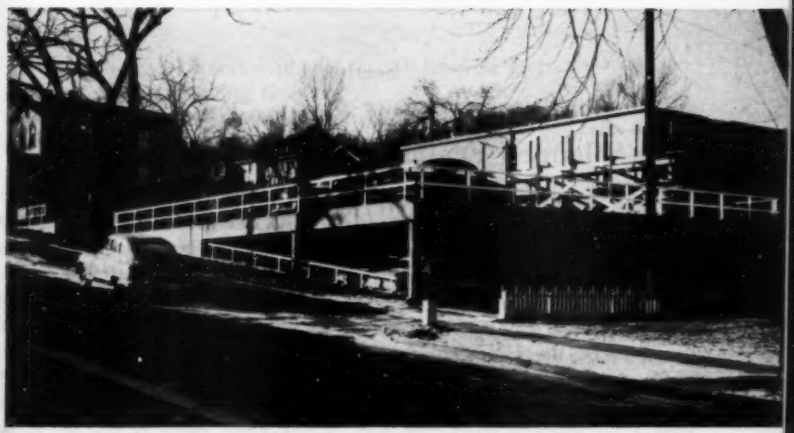
Horizontal expansion was provided for in the beginning by running pipes, ducts, and cables up to the wall that would join the new and old portions of the building. This saved the owners some substantial bills that would otherwise have been incurred for ripping out and rebuilding when the addition was put on.

The enlarged building, which is owned by a partnership of all the occupants, cost about $400,000.

At the moment, the men plan no further additions. But—just in case—they recently bought the remaining Dodge Street frontage in their block. Several years from now, the new plot may hold an annex. Unlike the present building, it will probably be planned from the start as a multi-storied structure—the number of stories depending on the demand for space at the time it's built. Each story will probably comprise two of the basic units.

STANDARD EXAMINING ROOM, only 8½′ x 10½′, is said to contain everything the doctor needs for interviewing and treating the average patient. Since most such rooms in the building are exactly alike, they can be used interchangeably. A recessed, fluorescent fixture in the ceiling provides over-all lighting.

CONSULTATION ROOM, also standard 8½′ x 10½′ size, is small but adequate, since it is used mostly for telephoning and dictating, and since the majority of consultations with patients take place in the examining rooms. Inasmuch as the room is windowless, the draperies are purely decorative.



DOUBLE-DECK PARKING saves valuable space on this slanting lot. (The picture was taken while the rear addition was still under construction.) END

The A.M.A. Report on

Dwight H. Murray, as chairman of the A.M.A. Board of Trustees, called this report "the most constructive and exhaustive relating to the problem of fee splitting ever written." The Journal A.M.A. published a one-page résumé in lieu of the complete report.

Actually, the complete report contains well over 15,000 words. Several responsible doctors familiar with it felt that the profession as a whole—which paid $15,000 for the study—was entitled to see the results. They therefore made the unabridged version available

Section 1

Inequity of Fees and the 'Planned Economy' in Medical Practice

A. There is general agreement among doctors that there are greater financial rewards for surgery than for medicine.

The survey of physicians' incomes prepared by the U.S. Department of Commerce, in collaboration with . . . the A.M.A., gives 1950 income figures for medical specialties and surgical specialties.

Internists, by far the largest group of strictly medical specialists, have a median income of $10,944 a year. General surgeons, the largest group in the surgical specialties, have a median income of $15,389 a year. And when a pediatrician ($10,695) compares himself to a neurosurgeon ($24,500), there is certain to be feeling.

Unethical Practices

to the editors of MEDICAL ECONOMICS for this specific purpose.

What follows is a 7,500-word condensation. It's sprinkled with pungent quotes from wire-recorded interviews. It's loaded with challenging commentary on the relative value of fees, the competition for surgical work, the restrictions imposed by specialty boards, the public hostility toward medicine, and the profession's disciplinary system. It's sure to be one of the most-discussed studies in years. As such, it's well worth your reading time.

The attitudes of general practitioners cast an interesting light on this discrepancy in compensation. In the East, where surgical privileges in the hospital are difficult for a general man to obtain, the general practitioner and the internist talk alike.

A general practitioner says:

Take a child with an appendix. You make the diagnosis, call the hospital, arrange for the admission, maybe for an ambulance, and you get $5. You refer the case to a surgeon who takes the appendix out in fifteen or twenty minutes, sees the child four or five times afterwards, and gets $150. I think the differential is too great.

An internist says:

I think it would be much easier to do four tonsillectomies and make $400 instead of doing one difficult diagnostic work-up for $25.

But the West Coast general practitioner who, more often than not, has surgical privileges, says, for example:

. . . It is a funny thing, but the surgical lectures were much better attended than the medical lectures were. Yeah, more G.P.s seem to be interested in surgery because probably they think there are bigger fees in surgery—and maybe there are. It's very, very diffi-


DR. DICHTER


MR. WATERSON


DR. TRUMAN

The Special Committee Sums Up

To the Members of the Board of Trustees:

We have completed our study of unethical practices and the related public relations problems. The report of our work is attached.

We feel that our analysis of these problems is sufficiently complete to suggest a basis for corrective action. Our report is not a statistical analysis. Interviews were conducted with doctors and patients selected at random in New York, Massachusetts, Ohio, Iowa, and California. Our method of research was qualitative, not quantitative, and the interviewers frequently spent hours with each doctor interviewed in order to get his *real* thoughts and feelings.

Mr. Waterson, our staff consultant, does not recommend spending more money on research. We accept his opinion that further interviewing would produce only repetition of the results which we have indicated in our report.

cult to take some strictly medical problem and conquer it and then get $250 or $350 for a fee.

Both surgeons and non-surgeons agree that the surgeon's earning period may be shorter. Both agree that with some kinds of cases his day's work may be more exhausting, both physically and emotionally. Yet the surgeons themselves are often uncomfortable about the discrepancy in fees.

We originally requested $31,000 for one year's work...In compressing our work into a half-year with a budget of $15,000, we were obliged to sacrifice something. Therefore, we acknowledge that the research has been somewhat curtailed and the planning for implementation has been left, for the most part, to existing committees and councils . . .

One observation from our staff's letter to the Committee seems significant enough to call to your attention. The staff said, "With a promise of anonymity from sympathetic interviewers, doctors have revealed their hopes and frustrations, their confusions and their convictions. Many are deeply affected by economic insecurity, by public hostility, by conflicts within the profession." . . .

Ernest Dichter PH. D., President of the Institute for Research in Mass Motivations, was associated with Rollen Waterson Associates in the staff work for the Committee . . .

All of the Committee felt the great seriousness of our project and gave freely of their time and talents.

Respectfully submitted,

COMMITTEE ON MEDICAL PRACTICES, AMERICAN MEDICAL ASSOCIATION

FELIX L. BUTTE, M.D.
JOHN S. DE TAR, M.D.
JAMES Q. GRAVES, M.D.
ERNEST E. IRONS, M.D.
LELAND S. MCKITTRICK, M.D.
WALTER L. PALMER, M.D.
STANLEY S. TRUMAN, M.D., CHAIRMAN

A general surgeon says:

You know, you feel terribly sorry, terribly sorry, when you always get the big fees and the attending man may only get an assistant's fee . . . He may have made the diagnosis; he may have done all the difficult work . . . The surgeon comes in and lowers the blade and removes the appendix and gets a $200 fee . . . I don't think it's entirely fair . . . I really don't.

B. Most doctors believe that pa-

DR. MURRAY

DR. HESS

DR. MARTIN

The A.M.A. Trustees Comment

The Board of Trustees has given serious consideration to the report of this special committee. The vast majority of physicians are honest and sincere; but there are those who, because of dishonesty or because of economic or financial pressure, disregard standards of ethics and flaunt [flout] the fundamental principles of right and wrong. These are the ones who reflect discredit on the entire profession.

The committee has suggested two general courses of action that can be taken in the effort to combat unethical practices: (1) to remove the factors that tempt physicians to be unethical, and (2) to discipline those who are guilty.

During recent years, considerable activity has been carried on in these two fields . . . But it is evident from the report of the committee that the work needs to be continued and intensified.

tients are more impressed with surgical therapy than with diagnosis and medical therapy.

A general practitioner said:

. . . Such therapy doesn't have the dramatic appeal of surgery, which still carries emotional connotations of magic, hoodoo, and so forth. [This] probably explains why surgery can command such high fees.

The surgeon [himself] is conscious of the dramatic overtones of his work:

. . . There is a certain element of the dramatic . . . seeing the illness begin

The Board would encourage other specialty groups or some county or district medical societies to conduct a study of a "relative value scale" such as has been produced by the thoracic surgeons. The Board believes that such pilot studies should be made before any [national] study is attempted.

In line with the recommendations of the committee, the Board has instructed the Department of Public Relations to incorporate into its educational program (1) an explanation of the value of diagnostic and medical work and procedures, and (2) an interpretation of the place of the physician in society—that he is a member of a profession whose prime object is to render service, but that he is also an individual who makes his living from his work and, like other men, is worthy of his hire.

The Board is determined that the public and the good name of the profession shall be protected from the small minority of physicians who engage in unethical practices. Mediation committees must be encouraged to fulfill their obligations . . .

BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

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May 7, 1955

and suddenly be concluded by a simple maneuver. It's very satisfying. It's the science of therapeutics in its highest form, surgery. You do something that has a beginning and has an end and oftentimes the cure is readily demonstrated. And the patient, unfortunately—it's because our popular education has failed in that respect—thinks of the doctor as a man in white, the fellow who has a mask on his face . . . and drips from the elbows. And there is something about that which is very attractive to the doctor, too.

This is not to say that internists do not take great pride in what they feel to be the intellectual distinction of their work:

...Due to the way medicine has been in the past, with the history of the barbers and the blood-letters . . . the populace is conditioned to either being tortured, in quotes, having blood let, or having something to show for what they pay . . . We [internists] sell them advice, diagnosis, and pills . . . And it takes a particular type of intellect to be able to appreciate this as a superior service.

Likewise the general practitioner has his particular psychological satisfactions:

I think the G.P. is the core of medicine. The whole of medicine is dependent on him, and we as a class do not have "numbers" for patients . . . We are *friends* of our patients and they come to us with *all* their problems.

Yet both the internist and the general practitioner feel that the surgeon has an advantage over them in the matter of status with patients and financial reward.

C. Because of the greater financial reward and the higher status with the public, there is intense competition for surgical work.

The intensity of the competition for surgical work is reflected in many ways. No one advises the young surgeon just to open his office and wait. Some doctors say the young surgical specialist should head for the smaller cities. Others say he should try for some kind of association or partnership with an established man. Others say he should perfect himself in one small part of his specialty and be a specialist within his specialty—to give himself a competitive advantage.

Some suggest that he find a part-time job in research or in a clinic. Everyone acknowledges that in most cities the young surgical specialist must use finesse, diplomacy, and careful self-promotion to wangle a hospital staff appointment. Many doctors blink at the fact that [the surgeon] may have to do a little general practice in spite of the restrictions of his board.

A general surgeon says:

General surgeons are pretty easy to come by and in a community of this sort . . . the province of general surgery is pretty well covered. And for anybody to come in and say "Stop sending your surgical referrals to the other surgeons with whom you are working and send them up to me," would be presumptuous.

A urologist says:

My field is generally overcrowded. I think it is also true of other surgical specialties. With more competition, the income is much lower. It causes some of us to lie awake nights wondering how maybe to get some union work, or some lodge work, and maybe some clinic work for contacts . . .

And the general practitioner who fights to keep his own surgical privileges observes the difficulties of the surgical specialist:

Many fields are becoming overcrowded. There are too many surgeons with not enough to do, and the G.P. is bona fide competition.

Another general practitioner says:

It's a lot easier, I presume, to be a surgeon and pick up a $300 fee for an hour's work, but you don't just walk into two or three surgical cases a day . . . You spend long, lean years waiting for one a week. It isn't all peaches and cream by any means.

These assumptions . . . speak for themselves. We have found that little statistical work has been done to measure the intensity of the competition or to prove the hardships that this competition entails for doctors doing surgery. But [such competition] seems to be accepted as common knowledge.

One young surgeon made a survey (the results of which were published under the name of J. Ray Thomas, M.D. . . .) which bears out these assumptions. He sent questionnaires to a small group of young surgeons and from their responses concluded:

It seems to me . . . that most young surgeons are well capable of and would like to do at least 250-300 major surgeries annually. This amount of surgery would justify the limiting of their practice, their long years of training, and would help to perfect their surgical judgment and technique. There are, however, only . . . 11 per cent of these doctors who reported doing more than 250 majors a year, and only . . . 20 per cent who are doing more than 200. In fact, 36 per cent of this group of surgeons who are in their third to fifth full year of practice are doing less than 100 major operations a year. This must be interpreted as a poor batting average for medical productivity and utilization of available skilled surgical services.

D. The economic aspect of this competition is not free and open. [It] is at least partially restricted by specialty boards and by hospitals which discriminate against general practitioners as a group.

. . . The economic consequences of the attempt to enforce the limiting of a specialist's practice are considered by many doctors to be an imposition. These doctors usually assume that the current policy of the boards is to make examinations increasingly difficult in order to decrease the number of surgical specialists.

Thus the conflicts among doctors over who should do surgery are deadlocked partly because rules and customs [that] limit a surgeon's practice are not acceptable to many surgeons.

It is evident that the surgical specialist *is* handicapped economically because he is arbitrarily cut off from the source of supply of his work. Some surgical boards frown upon his ever doing any work outside his specialty; and most of the surgical boards expect him to limit his practice [even] during the difficult first years of his practice, when he is in debt and has a growing family.

A general surgeon said:

And as they get out of their training and out of the Army they start . . . under the handicap of nothing to do . . . what might be called the routine stepboards [stepping stones] of medicine

. . . They go either one of two ways: either they break the rules of their board qualifications and do other things, or a few of them remain Simon-pure and struggle very hard. Many of them are able . . . because of . . . independent incomes.

Another surgeon said:

[Building up a practice is] very much slower if the individual stays within his specialty . . . does not do—as so many do—non-surgical work in addition . . . I would say that very few actually stick with their specialty, although they claim to.

A urologist said:

In specialties one usually relies on other physicians to refer patients . . . whereas in general practice one relies on patients . . . The general practitioner is more independent professionally and financially than the specialist. The specialist wouldn't dare speak his mind too often . . . [He] must be careful about his choice of words. It's an uncomfortable situation.

The survey made by J. Ray Thomas, M.D., gives reinforcement to what our interviewers were told. Those young surgeons who had been in practice less than three years had an average ratio of 24.2 office calls per surgical operation. Those who had been in practice five years had only 13 office calls per surgical operation.

The author concludes: "Although most of them would never admit it —for reasons of pride, prestige, specialty ratings—there is of necessity, not of choice, considerable general practice being carried on in many general surgeons' offices."

The arbitarary freezing out of all general practitioners from the hospital, where this has occurred, also appears to have intensified the conflict over surgery.

A non-certified surgeon said:

I can still have full surgical privileges in any hospital . . . only because I have been practicing long enough. If I were starting practice now, I would be forced to join the College or take the American Board in order to do the type of work that I am now doing. I would have no choice. I feel that the restrictions on the doctor are growing. In general, I don't feel that it has meant any advancement in the practice of medicine from the standpoint of either the patients or the doctors.

A board-certified man said:

And I think there is altogether too much regulation—[too much] trying to dictate to the various hospitals and to the various doctors what they should and should not do . . . I may be wrong on the subject, but I feel that a man that has received training and had a good education and has good experience should be allowed to do what he thinks he is capable of unless he gets into trouble . . .

In short, the surgical specialist is, to some degree, frozen out of the general practice of medicine, and the general practitioner is, to some degree, frozen out of the practice of surgery. Each group resents the freeze-out.

Without treating the question further for the moment, it is evident

that these two attempts at a "planned economy" for medicine have accomplished little to relieve the conflicts and dissension which surround the competition for surgical work. In fact, there are those who say that, whatever the non-economic motives behind these restrictions . . . the end doesn't justify the means.

To sum up: There are greater financial rewards for surgery than for medicine. There is higher public status for the doctor who does surgery. There is more intense competition among doctors for surgical work. The economic aspect of this competition is not now really free and open, but is at least partially regulated by arbitrary restrictions.

E. All these factors combine to create a climate which encourages unethical practices.

. . . No doctors in this present survey confided to the interviewers in so many words: "I split fees with Dr. X because this is the only way we can get along." In fact, doctors spoke heatedly about their conviction that fee splitting is wrong. But almost *no*

"Now, let's talk about you!"

doctor failed to mention some kind of justification for the fee splitter. And many doctors said they thought that fee splitting should be "legalized."

To read through some of their comments leaves the impression that they feel: Things being the way they are, what can you *do* about it?

A general practitioner said:

The young doctor becomes a victim when he tries to establish himself in practice. The young surgeon who tries to set himself up in an area very soon finds himself without a referral reservoir unless he is willing to split the fees with the referring practitioner.

A radiologist said:

The older doctors make no effort to take in younger doctors and so force them into fee splitting to make a living . . .

A surgeon said:

There was a ghost surgeon here in town . . . He would split the fee right down the middle and . . . he did ghost surgery for many men. He was a darn good surgeon, too! I don't know what happened to him. I suppose economics is the reason for it—the difficulty of making a living.

A general practitioner said:

I never engage in fee splitting myself, but I know it goes on and I can't honestly say that there isn't some justification for it . . .

Another general practitioner said:

A friend of mine, a young surgeon just out of training, told me not long ago that that was his situation . . . Patients aren't just standing in line waiting and it takes time to build up a following . . . The ideals get a bit tarnished or rubbed off when the economics of making a living for a wife and family hit you. So far as fee splitting is concerned, it's always been with us. I went back to Canada last year and it was still going on there. It's also going on here, and not necessarily the young surgeons, either . . .

. . . A general surgeon said:

. . . It is simply a question that when a practice is so widespread, as it is at the present time, and there are so many young surgeons who have a tough time getting surgical cases, the economic factor overcomes ethical factors . . .

An orthopedic surgeon said:

Of course you can, if you want to, on the first day you open up your office have it full of patients. Or you can wait, day in, day out, for the patients to come in. In the long run, being honest pays off. But it's tough in the initial stages.

. . . Another surgeon said:

I feel that a G.P. who has had ample training to do hernias or appendices has just as much right to do them as has a member of the American College. I think [the] tendency toward forced restrictions is as much responsible for so-called fee splitting and poor medical ethics and poor medical relations as anything else. Or, if you want to put it a little differently, I think [the] American College of Surgeons probably, in an honest effort to raise standards, has done more to *lower* them than anything else by the creation of improper restrictions, by setting up standards that are too rigid . . .

F. The relief of these pressures should make it easier for more doctors to maintain higher ethics in their practices.

Actually, none of the conditions which create a climate favorable to unethical practices are immutable. The Committee believes that all are susceptible of change, if medicine wants to make the effort.

. . . The interviews with doctors show clearly that all fees are a matter of tradition and public acceptability. When asked how he set his fees, every doctor, no matter what his field of practice, said: "I asked around the community and found out what other doctors were charging."

If the interviewer pressed the question further, they all admitted that they had no idea where the fees originally came from—and some of them were a little annoyed at being asked what seemed to them to be a foolish question. A tonsillectomy is worth $75 because that's just what it's worth!

The interviewers concluded that doctors display little scientific curiosity on the origin and basis for their fee structure. The exception to this . . . comes to light where doctors doing one type of practice feel that their financial rewards are below those of some other group. The internists have given considerable thought to why the surgeons are better paid.

Some indications of an approach to the problem have come to light. There is evidence, first of all, that the surgeon, who puts his price tag on only one part of his work, is underpaid for the rest of his time. His position is something like that of a housing contractor who charges for the building and throws in the services of the architect free.

As one surgeon said:

. . . The actual time taken in operating by a surgeon is a small proportion of all the time that he spends with his patient . . . Surgeons spend 50% or 60% of their time rendering some kind of psychiatric treatment, so that even as highly specialized an individual as an orthopod, dealing with low back pains and sciatica, spends a good deal of time allaying his patients' undue fears and helping them in an emotional way . . . Then as far as diagnosis is concerned, there is an old adage that a surgeon is just a good clinician who operates. Certainly another 30% of his time is spent with the problems of clinical judgment and diagnosis. Only a small proportion of his time is actually spent in the operating room performing the surgical feat that he is expected to do.

As one internist put it:

There are many general surgeons practicing $5 internal medicine in their offices, anticipating recouping their losses on the group of patients who can eventually be operated for a fee of several hundred dollars.

This device is known in the chain grocery store as the "loss-leader"—the item advertised and sold below cost to bring the traffic in. General practitioners who do surgery recognize that their medical practice is used to feed their surgical practice,

and frequently their surgical practice subsidizes their other work.

A further indication of the one-sided way in which the surgeon measures his own worth is seen in the relative value scale produced by the American Association for Thoracic Surgery. In this scale, the thoracic surgeons have set up six basic factors which should be evaluated in determining a fee and [they have] assigned to each factor a maximum number of points . . .

Under this system, each point can be given a monetary value, and while fees may differ from community to community, the *relative value* of different procedures is standardized. The maximum possible points for any one procedure is 77. Out of a possible 77 points, the maximum which can be allowed for pre-operative work is 5.

Pre-operative work is defined as: ". . . proper or sufficient history and physical examinations and other studies indicated by the specific case; study and evaluation of medical reports, X-rays, electrocardiograms, laboratory studies, etc. It also includes the time spent in consultations with other physicians; discussion with patients and relatives regarding the proposed surgery; time spent in preparing reports and in making any necessary arrangements which may be required for the case."

In allowing 5 points [out of a possible 77] for this enormous block of work . . . it would seem that the thoracic surgeons are selling themselves short—and by implication selling short all their colleagues whose practice of medicine is largely concentrated within this range of activity.

Practically all the surgical specialists who were interviewed gave lip service only to the custom of enforced restriction of practice. A sample of their remarks shows that many of them resent—or ignore—the rules, written and unwritten, which keep them from being doctors first and specialists second.

One said:

I did some general practice to get started. I happened to be certified in general surgery, but you've got to build up a certain amount . . . I don't know about other specialists, but I feel a specialist must have that leeway until he takes care of his overhead.

. . . Another point of view:

. . . As doctors grow up in the world, they should be given adequate opportunity to do surgery. The ones who emerge as specialists in surgery should be the ones who are qualified, rather than trying to take individuals immediately from the school and make them immediately highly qualified specialists . . . When their performance is adequate, then their certificates should be granted, and not the other way around. Then we would have mature men—mature enough in their fields and mature enough in medicine so they would not even dream of resorting to fee splitting . . . This would lead to no necessity for harsh rules . . . for "hatchet committees" and no need for Gestapo tactics in medicine . . .

As for the argu- [MORE ON 221]

'My Favorite Fee Story'

Every physician has his own pet yarn about a medical fee. Here are some that have been passed on to us recently. Have you a better one?

● Speaking of surprise fees, Dr. Walter Cane of Hempstead, N.Y., cites this one:

. . . Some years ago, a South American beef baron—he must have weighed three eighty—bulged into my office

and told me he wanted to lose a hundred pounds in two months.

He asked my fee. I made a quick estimate of his posh way of life and told him.

In seven weeks, while it took a lot of sweating on both our parts, he was shaved down to the size of a middle-class Farouk.

The day of his last visit, he thanked me profusely and handed me a gold-initialed wallet. Inside was a check for double my charge—plus a note. It said, simply: "You

deserve this, Doctor. I certainly couldn't pay you less than I paid my tailor for cutting three dozen suits down to size."

* * *

Dr. Justus Kaufman of New York City tells another one about a dollar-happy patient:

. . . I had just finished treating a well-dressed Chinese when he asked my fee.

"Five dollars," I said.

The patient took out a wad of bills, shucked off the rubber band, and handed me $100.

I gave him change . . . Seventy, eighty, ninety-five . . . He bowed.

As he was leaving, my nurse opened the door for him. He bowed again and tipped her with a $20 bill.

* * *

There's more than one way to collect an overdue fee, as Dr. S. C. Kasdon of Boston testifies:

. . . A pediatrician I know was called out on an "emer-

gency" at 3 o'clock one morning. The parents admitted that their child had already been ill a week but that they hadn't wanted to get a doctor sooner.

Six months later, after repeated requests, the bill for the visit was still unpaid.

Early one morning, on his way home from a call, my friend decided to give the recalcitrant parents a dose of their own medicine. He phoned and asked what they were going to do about his bill.

"What's the idea, calling at this time of night about your bill?" demanded the irate father.

"You called *me* at 3 in the morning and I came across, didn't I?" said my friend. "How about you?"

The bill was paid next day.

• • •

Often, a doctor treats a patient who feels he hasn't gotten the most out of medical care unless he horse-trades

over the fee. Here's what Dr. A. H. Margolis of Highland Falls, N.Y., says about such a person:

. . . I was asked to attend a man who had suddenly taken ill while vacationing near here with his wife. After I'd examined him, I had him taken to our local hospital, which is eight miles out of town.

A week later, his wife came to see me about my bill.

"I see," she said, "that you charge $5 for a daily hospital visit to my husband."

"That's right," I said, adding (in reply to her unasked question): "That's about as much as it would cost you to take a taxi to see your husband there." [MORE ▶

"But isn't there a bus that passes the hospital?" she asked.

"Why, yes. The fare is about 50 cents, I think."

She slapped two quarters on my desk and rose to leave. "Hereafter, Doctor, you can take the bus."

• • •

Every patient has his own way of expressing gratitude for medical care. Dr. Harvey B. McClellan of Xenia, Ohio, tells of his experience with a 60-year-old woman on whom he'd performed a partial gastrectomy:

¶ Her convalescence was complicated by bouts of tachycardia. She would phone me about them several times a day. One afternoon as she was leaving my treatment room, her gratitude got the better of her.

"Doctor," she said, fidgeting with her handbag. "Doctor, if I had a million dollars—"

She pursed her lips. "If I had a million, I'd pay you a thousand for what you've done for me."

• • •

Some favorite stories are about the fees a doctor never collects. Dr. Francis E. LeBaron of Foxboro, Mass., tells this one:

. . . Just before Mother's day one year, I happened to meet a woman patient of mine who'd owed me $300 for a long while. She told me—as she'd told me many times before—that she simply didn't know how she could pay my bill.

Maybe it was spring fever. Or concern over the woman's financial burden. Anyway, as soon as I got back to my office, I wrote out a paid-in-full statement for her and put it in the mail.

Three weeks passed, and my good deed went unacknowledged. Then we met again.

"Didn't you get my bill?" I asked.

"Your bill? Oh, yes, Doctor. But my husband threw it away without opening it." END

Major Medical Coverage Gets a Boost

Blue Cross and Blue Shield have now outlined a program for local plans that want to insure those 'big bite' expenses. Here are the details

By James E. Bryan

● Blue Cross and Blue Shield are at last ready to sail into the deep waters of major medical expense insurance. Local plans now have a clear chart to go by; and you can expect many of them to weigh anchor soon.

At the most recent joint Annual Conference of Blue Cross and Blue Shield Plans, held in Chicago, a general endorsement was given to a program for extending present benefits to cover illness lasting up to two years. To prove they meant business, the plans spelled out both the philosophy and the proposed terms of such insurance.

Naturally, these were recommendations only. But most of the Blue plans (except the few already in major medical) had been eagerly awaiting *some* guide to a field that has already been entered heavily by commercial insurers.

There has, of course, been growing public demand for protection against the catastrophic costs of long-term illness. So the new blueprint seems unlikely to gather dust.

Here's a quick run-down of its chief features:

MR. BRYAN, a former administrator of the Medical-Surgical Plan of New Jersey, is now a consultant in medical administration and public relations.

1. Major medical contracts would be available only to holders of existing policies. Thus, the privileges they now get would be extended automatically. The blueprint recommends, for instance, that any single illness be covered during a *continuous* 730-day period.

2. Subscribers would have to pay first-dollar costs—i.e., deductibles—for some services (as, for example, the first $50 in doctor bills *after* hospitalization). And they'd share the total load for some other services through co-insurance. But generally the great bulk of their illness expenses would be borne by the plans.

On a Service Basis

3. As is usually the case now, doctors and hospitals would be paid directly for their services. Fee schedules now in use would simply be extended.

4. There would be no ceiling on the total cost of any illness. De-

Proposed Benefits

• Following are the new and extended benefits recommended in the Blue Cross-Blue Shield program. Local plans are free to accept, reject, or change these benefits if and when they begin to offer major medical expense insurance to the public.

New Benefits

Visiting Nurse Services: **Up to fifteen visits a month during the 730-day maximum period of treatment for any illness—provided that such service is ordered by the attending physician immediately after the patient's discharge from a general hospital. Payments to be in accordance with the charges of the visiting nurses association. No co-insurance required.**

Private-Duty Registered Nurse Services: **Up to 240 hours in connection with any one condition, during hospitalization or immediately afterward, upon order of the attending physician. Patient must pay for the first twenty-four hours of such service, plus 20 per cent co-insurance thereafter.**

Appliances: **80 per cent of the cost of purchase or rental of nec-**

ductibles and co-insurance clauses would act as restraints on abuse.

5. There's a promise that *you* won't be abused, either. The fees you get "must be sufficient," says the report, "to reimburse [you] adequately." According to the suggested program, you'd be given special consideration if the regular fees were not fair compensation for your treatment of an unusual case.

The plans would open their doors to 85 per cent of the population. Subscribers would even be encouraged to seek preventive care. They'd get diagnostic services (if recommended by their physicians) by paying only 20 per cent of the cost out of their own pockets.

In addition, they'd be in line to get the following benefits that haven't generally been offered:

¶ Visiting nurse service after discharge from a general hospital;

¶ Private-duty services of a registered nurse;

essary appliances, with a deductible payment by the patient of $10 in any month. (Appliances are defined as devices worn by the patient, and respirators.)

***Drugs for Use Outside the Hospital:* 80 per cent of the cost of drugs that require a prescription, subject to a deductible payment by the patient of $10 in any month.**

Extended Benefits

Under Blue Shield

***Surgical and Obstetrical Professional Services:* Coverage whenever needed, subject only to the limitations in the basic plan. No deductibles or co-insurance required.**

***Medical Care in the Hospital:* Coverage up to 730 days, not exceeding one visit per day or five per week, if the payment is on a daily schedule. But the schedule may also be on a weekly, monthly, or case basis. Tuberculosis and mental disease are covered, unless the subscriber gets free care. No deductibles or co-insurance required except as the basic contract provides.**

***Post-Hospital Medical Care:* Coverage up to 730 days for all such services, according to the fee schedule, in a hospital for the**

¶ Purchase or rental of body appliances; and

¶ Drugs for use outside the hospital.

Compared With Others

How would the Blue plans' benefits stack up against what the commercial insurance companies have been offering?* Even a quick comparison shows that the doctor-sponsored program would offer a handsome package. For instance:

¶ Most commercial carriers set *both* dollar and time limits on coverage for a single illness. The only Blue Cross-Blue Shield limit would be the 730-day top on coverage for a single illness (which is longer than the typical insurance company allows).

¶ Demands for deductibles and co-insurance would be far less stringent, too. The usual commercial

* For a full account of the commercial plans, see "How They're Insuring Those Major Medical Expenses," MEDICAL ECONOMICS, November, 1954.

PROPOSED BENEFITS (CONT.)

convalescent or chronically ill, doctor's office, or patient's home. The first $50 is to be paid by the patient; but this deductible applies only once in any 730-day period. Coverage is limited to conditions that have required previous hospitalization. No co-insurance requirement.

***Anesthesia:* Coverage if it's not included in the basic contract.**

***Professional Services (X-ray, Radiation Therapy, Laboratory Examinations, and Physical Therapy):* 80 per cent of the charges after the patient has paid the first $10 per month, when such services are prescribed by the attending physician. (These benefits, by the way, are sometimes paid for by Blue Cross instead of Blue Shield.)**

Extended Benefits

Under Blue Cross

***Care in a General Hospital:* The same benefits now available to registered bed patients under basic contracts, but extended to a maximum of 730 days. No co-insurance.**

***Mental Conditions, Chronic Alcoholism, Drug Addition, and Pulmonary Tuberculosis:* Even if these diseases are now excluded from the basic contract, care is to be provided for 730 days (including**

contract requires the patient to pony up at least the first $250, while some firms ask as much as $1,000. The highest deductible recommended for the new scheme is $50.

As for co-insurance, it would seldom be required under the Blue plans—and then only 20 per cent. The commercial rate is usually higher; and it's applied to more clauses in the contract. Blue Cross-Blue Shield would rely heavily on the M.D. himself to keep the patient from making capricious use of optional services.

¶ Finally, by paying a set rate for each service *as rendered*, the doctors' plans would undoubtedly go easier on the patient's pocketbook. It naturally takes close ties with the medical profession to provide any such service-type contract; so the commercial insurers must pay claims on an indemnity basis. That way, the patient is likely to increase his medical expense account all along

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any basic contract days) in a contracting hospital or Government hospital other than a Veterans Administration or Marine hospital. No co-insurance required.

Hospital Care in a Contracting Convalescent or Chronic Institution: **Coverage of 80 per cent of the cost of care for a maximum of 730 days, including any basic contract days, with these requirements: (1) referral must be made by the physician; and (2) admission to the institution must be simultaneous with the patient's discharge from a general hospital.**

Accident and Ambulatory Surgical Cases: **To the extent not covered by the basic contract, coverage for service provided by a hospital in its out-patient department. No co-insurance required.**

Out-Patient Service for X-ray Examinations, Radium Therapy, Laboratory Examinations, and Physical Therapy: **80 per cent of the cost of all such care over $10 in any month, when the patient is referred by a physician for any condition except emergency accident treatment or minor surgery.**

Oral Surgery in Accident Cases: **Recommended for inclusion in the contract unless it's prohibited by local statutes that limit provisions for dentists' services. (This benefit is sometimes offered by Blue Shield instead of Blue Cross.)**

the way. Hence, a need for tighter brakes in the commercial plans.

Obviously, there'd also have to be some brakes in the new program. Custodial and domiciliary care—as in homes for the aged or in rest homes and health resorts—would be sharply excluded, for instance. (But a patient in a hospital for the convalescent or chronically ill would be eligible for coverage, *if* the doctor recommended it *and* if the patient had just been discharged from a general hospital.)

There would also be a keep-out clause for patients whose care is a legal responsibility of government or of an employer. This would rule out, for the most part, compensation and mental illness cases. But where government isn't responsible for care, the patient could get coverage for mental conditions—as well as for drug addiction and chronic alcoholism.

For various reasons, the following would also be excluded: claims for eyeglasses, hearing aids, cosmetic surgery, travel, and ambulance service.

They're Not New

Actually, such exclusions are already written into the usual contract for basic short-term care. The blueprint urges that no new exclusions be added when a local plan extends its service. Similarly, the planners turn thumbs down on any waiting periods beyond those already required.

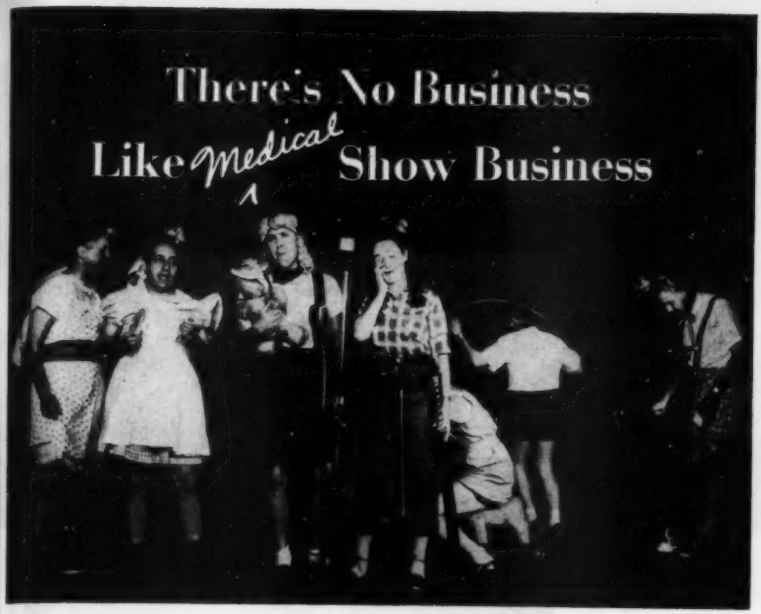
One question still remains to be answered: Should an attempt be made to *list* all eligible diseases; or should the way be open to paying for *all* disabling conditions except those that are the responsibility of government? Since there's something to be said for both schools of thought, the local plans face a hard decision.

Obviously, each plan must also fix the actual costs of major medical coverage in its area. But the leaders present at the national conference in Chicago did estimate what the average subscriber would probably have to pay. The figures are surprisingly low: In addition to the cost of his basic contract, the patient might be charged from 75 cents to $1 monthly for a single-person major medical policy, and from $1.50 to $2 for a family contract.

Rates Are Low

These rates, of course, are only intelligent guesses. But even allowing for necessary boosts in some places, they're low enough to look good against the commercial insurance rates now available. So—money-wise as well as coverage-wise—patients should be tickled pink by their extended Blue Cross-Blue Shield insurance when they get it.

As for doctors—well, it's been in the cards for a long time now. And the blueprint is at least designed to keep leadership in the health insurance field where it belongs: in the hands of U.S. doctors. END



These doctors and their wives regale their colleagues with a musical revue that's good medicine for the audience—and good economics, too

By Lawrence C. Goldsmith

● As the legs of the chorus girls swung high, the G.P. in the first row whispered to the man next to him, "That blonde up there . . . she's my wife."

"The redhead's *mine*," said his neighbor, a surgeon.

Neither physician was surprised, for all the actresses were doctors' wives—and all the actors were doctors.

With good reason, too: For this was the cast of "The Private Lives of Doctors' Wives," the Maryland medical community's latest—but by no means last—excursion into

musical comedy as a fillip to its state society's annual convention.

The show played to a packed house in Baltimore at the 1955 convention ball; and it netted—in entertainment-world lingo—over 2 Gs at the B.O. (The $2,000 will finance the philanthropic activities of the Woman's Auxiliary to the Baltimore City Medical Society, which sponsored the production.)

Nearly a score of physicians performed; and most of them *really* had to act. For example, Obstetrician Samuel Rubin played a surgeon; while Surgeon Howard Patt was cast as "Dr. Obstrish."

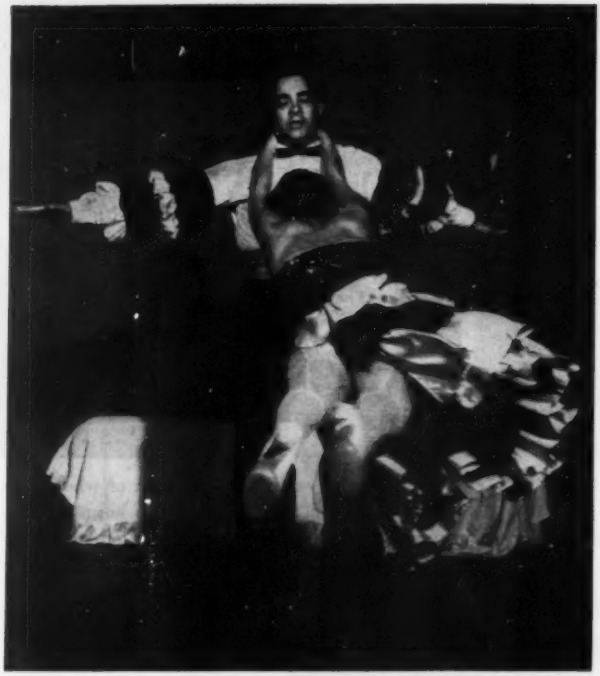
She Just Waits

According to the various skits, the private lives of doctors' wives consist largely of waiting for their husbands to come home. Occasionally, a lonesome wife pines for a gigolo

INTIMATE SCENE in "Dr. Gepe's" home shows Dr. Harold Rosen explaining to his stage wife that a coronary has forced cancellation of their anniversary celebration plans.

HOSPITAL LINE-UP brings to life a lonely wife's painful dream of what probably transpires during the long hours when her husband is on hospital duty. Several of the dancers—all now married to doctors—are former nurses.

COSTUME CONSULTATION takes place between Drs. Theodore Kardash (left) and Harry Beck. [MORE ▶



OUT FOR A SPIN: Dr. Charles Tommasello, a former professional dancer, twirls his partner in a tango specialty number.

(she can't understand *all* those night calls). But generally she's a stoic who keeps on making—and having to break—social engagements. And her doctor-husband just wishes she would give up attempting the impossible.

This bittersweet theme was tricked out gaily in song and dance, including even a tango by a 66-year-old surgeon, Dr. Edward R. Johnson. Over fifty performers romped through the revue, voicing the woes of medical wedlock in ten songs—all with original lyrics.

A typical sample: Singing lustily to the tune of "I Can't Give You Anything but Love," the doctor-

members of the ensemble laid it on the line:

I can give you everything but love, Baby.

Love's the only thing I've no time for, Baby . . .

They Did It Before

The revue was written, cast, choreographed, and directed by Edith Taylor, wife of Psychiatrist Irving J. Taylor of Ellicott City. She's an old hand at Broadway-in-Baltimore by now: She masterminded a similar production for the convention ball of 1953. Last year, when her domestic life made too heavy demands, the show was skipped—with the result that the attendance at the ball dipped one-third.

Mrs. Taylor says that writing a show with doctors in the cast is child's play compared with directing rehearsals. "What do you do," she asks plaintively (and rhetorically), "when your leading man's always being called out for an emergency appendectomy?"

Even during the performance, she adds, "I never knew in one act who'd be with us the next, and who'd be summoned away. Luckily, though, the final curtain rang down without a single call. Not even for an OB man."

MAMBO NUMBER is executed by Dr. Irving J. Taylor and his wife, who also wrote and directed the show. END

'Blue Shield Didn't Pay Me Enough'

In some areas, committees of private physicians have been set up to listen to their colleagues' complaints about inadequate allowances. Here's how one such committee acts on what it hears

By Wallace Croatman

● Early this year, a Brooklyn surgeon set out to remove a hydatidiform mole from the uterus of a 44-year-old woman. He began by performing a hysterotomy, since the patient was anxious to preserve the uterus if at all possible. But after running into severe bleeding, as well as other difficulties, he decided he had no choice but to do a hysterectomy as well.

Soon afterward, the woman filed a claim for surgical benefits with United Medical Service, the Blue Shield plan for seventeen counties in downstate New York. Her case was evaluated by a U.M.S. staff physician, and the surgeon was sent a check for $125—the scheduled allowance for a hysterectomy.

But the surgeon wasn't satisfied. He felt that the case had been comparable to the Porro operation, which rated a $175 allowance in the health plan's book. So he telephoned the local U.M.S. office and asked to have the case checked by the Physicians' Review Committee.

A few weeks later, this committee—composed of a number of private physicians—met at the Biltmore Hotel

in New York City. The Brooklyn surgeon's complaint was one of those they discussed. It took them only a few minutes to decide that the health plan's initial check in this case had been too small for the work involved. By a show-of-hands vote, they agreed that another payment of $50 should be made.

Result: The surgeon got the $175 he considered a fair fee, and the patient didn't have to pay a cent out of her own pocket.

United Medical Service, like any other health insurance plan, draws up its fee schedules to fit average cases for low- or middle-income persons eligible for service benefits. But many an M.D. encounters cases in which the average fee simply isn't enough.

As a matter of policy, the nation's Blue Shield plans try to keep participating physicians satisfied. That's why some of the plans have set up review committees of private M.D.s, and that's why they've been given broad powers to adjust allowances.

The Physicians' Review Committee in New York has existed for a long time. Prior to 1951, however, it was made up entirely of medical members of the U.M.S. board of directors. And as one member recalls the situation, "Private physicians seemed to feel that this committee was interested only in saving Blue Shield money."

On the suggestion of Dr. Leonard J. Raider, vice president of U.M.S., the present committee was formed in order to combat any such suspicion. It consists of seventeen practicing M.D.s, each appointed (for varying terms) by one of the county medical societies sponsoring United Medical Service.

The doctors held their first meeting in March, 1951; and they've met on a more or less monthly basis ever since. The committee's major functions:

¶ It acts as a court of appeals for doctors who are

dissatisfied with the fees Blue Shield has allotted them.

¶ It establishes allowances for procedures not listed on the fee schedule.

¶ It recommends (but can't enforce) changes in the fee schedule.

¶ It recommends (but can't enforce) changes in U.M.S. medical policy.

¶ It interprets established U.M.S. medical policies that need clarification.

Although the committee sometimes gets patients' complaints, the overwhelming majority of its problems are dumped in its lap by doctors. And in nine out of ten cases, the protest concerns the size of a specific Blue Shield allowance. (Only occasionally does the committee have to tackle such questions as whether a case involves a pre-existing condition, or whether such-and-such a procedure really constitutes surgery.)

On the surface, at least, doctors and patients come off fairly well at the hands of the committee. During its first four years, it recommended

"This had better be something serious."

higher allowances in 55 per cent of the cases referred to it for consideration.

But it's also true that the committee seldom recommends as *much* of an increase as the plaintiff has requested. The final allowance is often set somewhere between the original amount and the amount asked by the physician. (In view of the service benefits basis for U.M.S. payments, this is understandable, of course.)

To quote one New York practitioner: "The Blue Shield committee tends to make the challenged fee less low, rather than to make it really high. But at least that's something."

How Cases Reach It

When a doctor wants to question a Blue Shield allowance, he usually writes or phones the central office. Then, if the office staff can't settle it to the physician's satisfaction, his grievance is referred to the Physicians' Review Committee. (Actually, not many need to go that far: In its first four years, the committee had to handle only 400 complaints —or about one out of every 4,000 cases processed routinely.)

The doctor whose grievance is to be considered by the committee is asked to supply all pertinent details in writing. He isn't usually permitted to plead his case in person; committee members aren't supposed to know the identity of those involved. Thus, each complaint is handled on the basis of a typed report compiled by the staff. And such reports omit all names of doctors, patients, and hospitals.

No Questions Asked

Once the committee rules that an extra allowance is in order, the money is paid without question. Blue Shield officials haven't yet overruled the committee's judgment in any specific case.

Sometimes, of course, the *plaintiff* isn't satisfied. In such an event, he can submit new evidence and ask to have the case reconsidered at a later meeting.

Few doctors go to all this trouble, however. Consider the experience of a Manhattan man who *did* pursue his complaint to the bitter end:

He had questioned the plan's allowance of $15 for an excision of a subcutaneous cyst: He felt he should get quite a bit more. In its first review of the case, the committee had ruled that Blue Shield's allowance was adequate. Forced to reconsider, the committee doctors conceded that they had perhaps underestimated the work involved. So they voted to pay the plaintiff an extra $10.

They Aren't Paid

The recipient of such a small monetary adjustment might possibly assume that the committee members have some financial stake in United Medical Service. But he'd be quite wrong. The doctors decided back in 1951 not to accept any pay for their

services. Their only tangible reward is the dinner that the health plan pays for before each monthly meeting. (The plan also provides hotel accommodations for one or two men who live at some distance from New York City.)

All told, the program costs Blue Shield a little more than $100 a month—which must stand as some kind of record for low-cost medical consultations.

From twelve to fifteen members usually attend the monthly meetings at the Biltmore Hotel. Dinner conversation is strictly social; it runs the gamut from baseball to taxes. A summary of the evening's agenda is passed out along with dessert. Then, for two hours or more, the doctors discuss the twenty or so cases usually described in the summary.

Dr. Henry E. McGarvey, a Bronxville physician, acts as the non-voting chairman. But there's no effort to abide by parliamentary procedure. Informality reigns. No official recognition is needed before a member can speak; and everybody manages to come up with a few comments during the evening.

There's a lot of good-natured banter, too. But the impartial observer can't help being struck by the

Big Leaguer in the Bushes

● Dr. Myron C. Barnes has good reason to grin: He recently received an American Association of Nurserymen award for "achievement in industrial landscaping and beautification." The planting around his office in Ontario, Calif., the association says, is appropriate, distinctive, and conducive to "employe and civic pride." Armstrong Nurseries designed the landscaping.

amount of serious work that gets done—and by the very evident determination to be fair.

The committee's final judgments on U.M.S. allowances are usually based on four factors: the difficulty of the work, the length of treatment, the special skill needed, and the usual charges for low- or middle-income patients. If the doctors are reviewing an unlisted procedure, they also consider what the plan allows for comparable procedures.

At a recent meeting, the committee reached definite decisions in nineteen cases. And in fourteen of them (a higher-than-usual proportion), it recommended at least some increase in fees. Here are capsule summaries of a few cases considered at that meeting:

Typical Cases

¶ A Manhattan doctor did a rare type of eye surgery on a 4-year-old girl. For this "extremely complicated and extensive" operation, he felt that the health plan's allowance of only $150 was far from satisfactory. After studying the operative report, the review committee raised the allowance by $50.

¶ A 54-year-old woman was operated on for a de- [MORE ON 212]

Can the State Force Non-Emergency Surgery?

Yes, says this court, in overruling the parents of a boy with a harelip who looks to 'forces of the universe' to close his cleft palate

By John R. Lindsey

● This is the story of a 13-year-old boy who shares his father's convictions that only "forces of the universe" can heal the harelip and cleft palate he was born with. It's also the story of a court decision of concern to the medical profession. For the decision may set a precedent for intervention by the state in family decisions to forgo non-emergency medical treatment.

In any real emergency, like that of a child facing blindness from sarcoma of the eye, the courts have always overridden parental objections to surgery. At the opposite extreme, no court has challenged the parents' right to protect from the knife the healthy child with six toes.

Now, in the broad twilight area between these poles, a new precedent is taking shape. It stems from a decision in the Appellate Division of the New York State Supreme Court, ordering surgery for the boy with the harelip—against his will and in spite of his father's protests.

If upheld by higher courts, the decision would mean that physicians could do more than *recommend* surgery in certain non-emergency cases. They could *insist* on it.

The boy in the case is Martin Seiferth Jr. Seven years

ago, when he started school in Buffalo, N.Y., his teacher observed with horror that his lip was badly split and that his front teeth were conspicuously decayed. Questioning him, she learned Martin had never been to a doctor.

Soon afterward, a child psychologist for the health department, Richard L. Slosson Jr., talked with Mr. and Mrs. Seiferth and their son about his problem. The family was told that Martin could have surgery, the necessary orthodontia, and a follow-up course in speech training. Regardless of the family's finances, ways could be found.

Martin's father, who runs a small delicatessen in Buffalo, listened carefully to everything the health department's representative had to say. Then he said no. He hasn't changed his mind since.

His reasons? First of all, Seiferth believes in "forces of the universe." He's convinced these forces can help his son to heal himself. He won't say that this belief of his is religious. "It has no name," he says.

Secondly, Seiferth has no use for physicians. Once, twenty-five years ago, a doctor told him that he had tuberculosis and that he had only a year to live. The doctor's dead now; Seiferth himself is hale and hearty.

"I cured myself through thought and the belief that God will come to one's aid," says Seiferth. He's sure his son can do the same.

But does he know of any cases of cleft palates closed by "forces of the universe?"

"No," Seiferth says, "but [I do know of] cases of cancer of the rectum that were cured without surgical aid."

Two years ago, after all efforts at persuasion had failed, Dr. William E. Mosher, deputy health commissioner of Erie County, petitioned the Children's Court for custody of the boy. Dr. Mosher held that Martin was a neglected child—neglected because his parents had denied him medical assistance.

The Children's Court judge denied the petition on

March 1, 1954. He gave these reasons:

¶"Arbitrarily to force this child to submit to surgery, which he has been conditioned to fear, might do more harm than good.

¶ "There is no serious threat to his health or life."

The judge added that he'd have ordered surgery "without hesitation" if the case had been started before the child "acquired convictions of his own." But now, in the court's opinion, Martin was a "mature, intelligent boy." (He's currently in the seventh grade, at the age of 13.)

Early this year the Appellate Division of New York's Supreme Court reversed the Children's Court ruling, 3 to 2. The majority's findings were these:

1. The boy is "neglected" and "physically handicapped." As such, he is subject to the state Children's Court act. This provides that "a suitable order may be made for the [medical] treatment or education . . . of such a child in its home, a hospital, or other suitable institution." The law specifically "contemplates medical treatment over the opposition of the parents."

2. There need be no "emergency" for a court to invoke this law. "If it applied only where life is in danger, it is difficult to see where there would be much room for discretion." And the law specifically gives the court wide powers of discretion.

3. The boy's failure to consent is "legally immaterial because, as a result of youth and misguidance, he does not appreciate the nature of the operation or the consequences of the alternative."

4. The time element is important. "By the time he is old enough to realize what is best, it may then be too late."

5. "The psychological effect of a forced operation . . . would seem to be small in comparison with the psychological effect of permitting the child to enter adolescence with such a deformity and handicap."

Minority's Dissent

The minority on the Appellate Division sided with the Seiferth family. The objections they raised included these:

It wasn't certain that surgery could be performed "without dangerous mental reaction" . . . This wasn't "an emergency in which the health or life of the child was at stake" . . . The minority therefore couldn't "subscribe to the view that this 12-year-old boy of normal intelligence should be compelled to submit to surgery, which he and his father seriously oppose."

That's the story. If the latest decision is upheld by the New York Court of Appeals—at press time, its decision had not been handed down—it may well raise broad questions for doctors everywhere. Even questions as broad as this one:

How far can the state go in prescribing for the health of its citizens?

END

How to Get Started As an Investor

Here are the things one young doctor learned recently when he opened his first brokerage account. His story may serve you as a refresher course in the mechanics of placing market orders

By Alton S. Cole

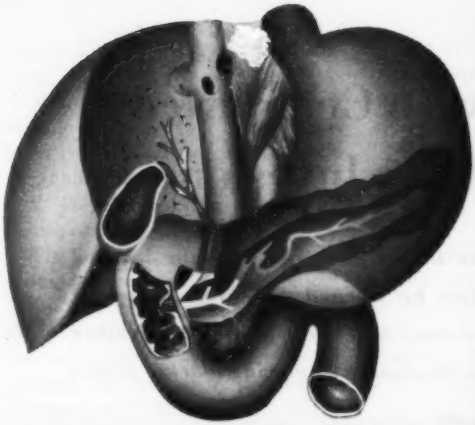
● Dr. Herbert Shafer, a 34-year-old general practitioner, recently got over one of life's high hurdles: He became an investor in common stocks.

Before that, the expenses of getting started in medical practice and in family life had soaked up just about all his available capital. He had, however, managed to hang on to the Government savings bonds he'd bought toward the end of World War II.

Not long ago, they began to mature. Just as Uncle Sam had promised, he found himself with $100 for each $75 he'd put into them ten years before. Not bad, thought Dr. Shafer—until an older colleague pointed out one disturbing fact: In what it will buy, $100 today is worth less than $75 was ten years ago.

Right then, Herbert Shafer resolved to protect himself against any further inflation by putting a major part of his bond proceeds into good common stocks. Besides, he figured, his practice had passed the break-even point; soon there might be surplus earnings to invest.

But how did you go about picking a broker? Were there



constipation
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related
functional
G. I. distress

markedly relieved in
8 out of 10 patients*
by inexpensive, physiologic
stimulant

DECHOLIN® with Belladonna

improved liver function* PLUS *reliable spasmolysis

Steps up flow of dilute bile by *hydro*choleresis • physiologic elimination without catharsis • relieves spasm • no cramping • no evidence of tolerance • helps establish normal bowel habits.

One or, if necessary, two *Decholin*/Belladonna Tablets t.i.d. gives your patients more effective relief of constipation and related G.I. complaints: flatulence, bloating, belching, nausea and indigestion.

Each tablet contains *Decholin* (dehydrocholic acid, *Ames*) 3¾ gr., and extract of belladonna ⅛ gr. (equivalent to tincture of belladonna, 7 minims). Bottles of 100 and 500.

*King, J. C.: Am. J. Digest. Dis. 22:102, April, 1955.

AMES
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any who'd deign to deal with a customer having only a few hundred dollars to invest at a time? What red tape was there to opening an account? How did you place a stock purchase order? How did you even pick a stock to purchase?

Dr. Shafer had a general practice in a Midwestern city. At his bank, he was referred to the firm of Putz & Cawles, which had a local office. A couple of days later he phoned the P & C number, asked for the manager, told him who he was and how he'd been referred.

Conservative Investor

"I'm considering," he said, in his most businesslike voice, "the purchase of a few sound common stocks from time to time. Nothing in the way of a very large commitment for the present, understand. Matter of fact, I . . . ah . . ."

"Certainly, Doctor," said the manager, affable as apple pandowdy. "We'd be only too happy to serve you. Many of our most valued customers follow a similar plan, investing only small amounts at a time. Perhaps ten shares of this or twenty of that. Very sound, conservative procedure, in our opinion."

". . . ah, conservative, yes. That's exactly what I had in mind for my investment program."

"Well, I think you're wise, Doctor." He really sounded like a decent sort. "And I know how busy you medical men are. Suppose I have our Mr. Humphrey drop in at your office? He's one of our ablest account executives."

Dr. Shafer was surprised and pleased. The following Thursday afternoon at 5 o'clock, he suggested, would be a convenient time.

Broker's House Call

Humphrey showed up on the dot—an agreeable, bespectacled, steady-looking chap, minus any stamp of the high-pressure salesman. From a P & C brochure the doctor had received by mail that morning, he knew that his caller (like all customers' men employed by New York Stock Exchange member firms) was specially trained in his job and had passed an Exchange-sponsored examination. Humphrey could be expected to know in detail the mechanics of buying and selling securities and to have a fair knowledge of investment theory and practice.

In half an hour, he and the doctor covered a good bit of ground. Dr. Shafer decided that, as his bonds matured over the next year or so, he'd be putting about $5,000 into stocks. "From then on," he said, "I might add a couple of thousand a year, depending on what I feel I can afford from time to time."

"I see," said Humphrey. "That means you probably wouldn't want to join a monthly investment plan. As you may know, such programs give the investor a chance to buy stocks piecemeal, on a budgeted cash-payment basis. But they're de-

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CAPSULES

Mephate relaxes muscle spasm without impairing strength, diminishes tension and anxiety without clouding consciousness.
Each capsule contains mephenesin 0.25 Gm. and glutamic acid hydrochloride 0.30 Gm.

1. Bender, T. J. Jr.: at Mtg. Med. Assoc. St. Alabama, Mobile, 1954.
2. Jessup, R., Murray, R. J. and Rossi, A.: Amer. Pract. & Dig. of Treatment, 5:792, 1954.

A. H. ROBINS CO., INC. · RICHMOND 20, VIRGINIA
Ethical Pharmaceuticals of Merit since 1878

signed chiefly for the man who intends to invest set amounts at periodic intervals."*

"I'd rather not tie myself down that way. I'd like to buy stocks whenever I feel I'm ready to." Dr. Shafer changed the subject: "And it seems to me my primary objective should be long-range growth of principal."

Humphrey nodded. "I don't suppose you'll be buying on margin, Doctor?"

"Absolutely not." Herbert Shafer didn't know much about margin buying, except that it was chancy and had faintly evil connotations.

Unwise to Borrow

"Right. Unless a man has had a good deal of market experience, he shouldn't borrow money to buy stocks. Under present Government regulations he *can't* borrow over 30 per cent of the current value of the stocks. But it's still no game for the inexperienced."

"And that's what I am." The doctor paused. "I'm so inexperienced, frankly, that I don't even know just what securities to invest in."

Humphrey offered to have his firm's research department, at the main office in New York, draw up a $5,000 program to the doctor's own specifications (growth first, income second). This department would, he said, make recommendations for specific stock purchases in specific amounts.

"What they'll do," he explained, "is to select six or seven likely looking issues in sound industries having what we consider the strongest prospects at this time. As your bonds mature, you can gradually build up your stock holdings on the basis of that program, subject to a continued favorable view of those stocks and industries by our research department."

"Sounds good," said the doctor. "What's the fee?"

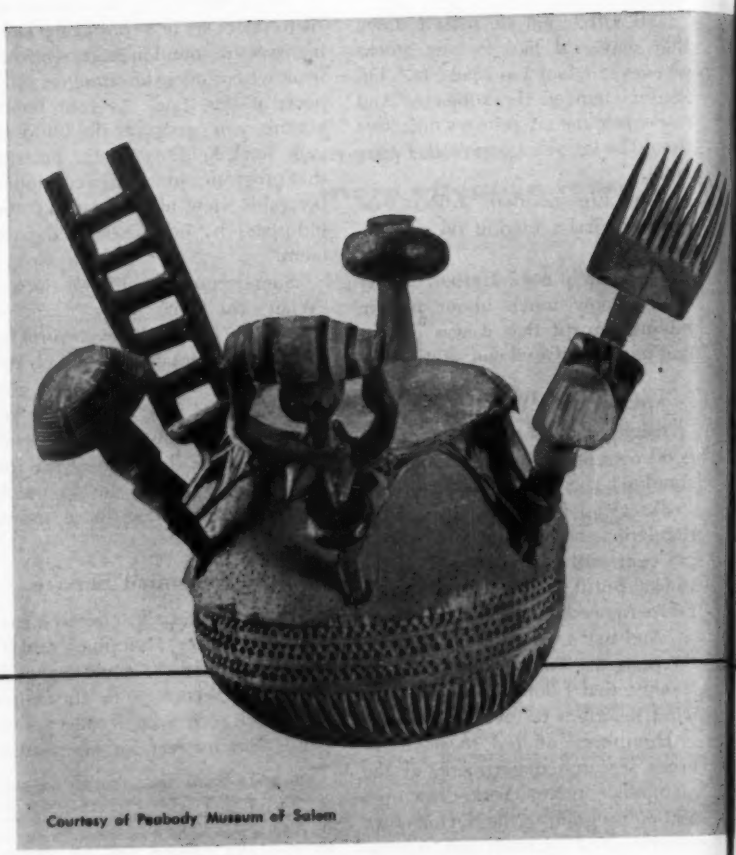
"No fee. Practically every brokerage house maintains a research department for the free use of its customers. Ours has over forty researchers and analysts, each specializing in two or three industries, following day-to-day developments among companies in those industries."*

Free Custodian Service

Putz & Cawles also offered a free custodian service, Humphrey said. If the doctor liked, he could leave all purchased securities in the firm's safekeeping. It would collect dividends and interest for him, either

*For a full discussion of this subject, see "What About Those Monthly Investment Plans?," MEDICAL ECONOMICS, May, 1954.

*Brokerage-house advice on the purchase or sale of securities may not always be completely disinterested, particularly with a firm that isn't a member of a recognized securities exchange. An unethical firm, for example, might advise purchases or sales chiefly for the purpose of promoting commission business for itself. For this and other reasons, brokerage-house statistical services should not in general be considered as on a par with advisory services offered on a fee basis by reputable investment counsel firms that are not in the brokerage business.



Courtesy of Peabody Museum of Salem

ASHANTI DRUM
FOR DEMON DANCING

When illness struck a member of the Ashanti tribe of the Ga country of West Africa, the medicine man—beating rhythmically on this drum—invited the disease demon to dance out of the patient's body. The ornaments represent signs and symbols which were then supposed to lure him off on a trip.

Unsyncopated and hardly terpsichoreal, modern remedies are more effective and more numerous. The number and complexity of available drug specialties has made PHYSICIANS' DESK REFERENCE, the annual prescription drug directory, as indispensable to the practicing physician as his prescription pad.

PDR PHYSICIANS' DESK REFERENCE

published by Medical Economics, Inc., Oradell, N. J.

mailing him a check or crediting his account. It would keep an eagle eye out for any stock purchase rights issued to him. It would prompt him either to exercise them or to sell them before expiration (many stockholders suffer loss by failing to do either). Finally, it would send him monthly statements of investment income and capital gains and losses, helpful to him at income-tax time.

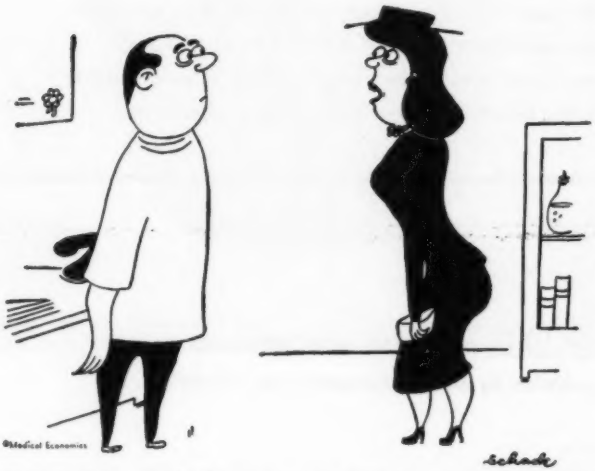
"And no matter how inactive your account," Humphrey told him, "we make no service or carrying charge. Some firms do, you know—perhaps a couple of dollars a month, if the account isn't earning its keep in commissions."

"Yes, I know," said the doctor, who didn't know anything of the sort. "By the way, how much are your commissions?"

The Broker's Cut

The customers' man handed him a commission schedule. Rates ranged from around 5 cents a share (on stocks selling at less than $1) to 50 cents a share (on those selling at $240 up). "Roughly speaking, the commission on each transaction will run from one-half to three-quarters of 1 per cent of the amount involved. Also, there's a small Federal tax."

The doctor filled in a signature card, thereby formally opening an account. Humphrey promised to wire the head office in the morning and



"I just don't know what's wrong with me today . . . What's new?"

essential to all . . .

Folic Acid

. . . lacking in some

Everyone, regardless of age, needs some Folic Acid. This important member of the B-complex contributes to the formation of all body cells. It is, therefore, of special significance during infancy and pregnancy. Although many foods contain it, some diets lack it. Where such a deficiency exists, a supplement to the diet is often indicated.

In selecting a multivitamin preparation, be certain you choose one containing adequate amounts of Folic Acid. A variety of such products is offered by practically all leading pharmaceutical manufacturers. This message is presented in their behalf.

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give the doctor a ring as soon as the recommendations from the research department came through.

"Perhaps at that time you'd like to have a look at our offices," he added.

Base of Operations

Dr. Shafer heard from him a week later and dropped in the next afternoon. The Putz & Cawles office was a large, rectangular room off the lobby of the town's largest hotel. A big, black quotation board took up one entire wall. It was covered with white symbols—"X" (which Humphrey said stood for United States Steel), "GM" (for General Motors), and a couple of hundred others, representing the most active issues among the 1,500-odd traded on the New York Stock Exchange. A small section of the board was devoted to Curb Exchange stocks.

Under each symbol were five figures. They showed the last price at which the stock had sold the day before, its current day's opening price, its highest and lowest prices since, and the price of the latest transaction.

The board was electrically operated by wire from New York. It was constantly whirring and clicking away as here and there the figures changed. In the middle of the wall, toward the top, was a small, hooded movie screen, about six feet long and a foot high, which showed a projected ticker tape moving steadily along. Here again the stock symbols appeared, each followed by a figure indicating how many hundred shares of the issue had just changed hands on the Stock Exchange trading floor. Another figure gave the price, thus: "X 4s 75⅜." (Humphrey explained that 400 shares of U.S. Steel had sold a few minutes before at $75.375 a share.)

The P & C board room was noisy and smoke-filled. Mingled with the chirping of the quotation board was the clatter of news tickers (with bells to signal important flashes), the buzz of phones, and an undercurrent of conversation. Humphrey and the doctor were seated at the former's desk, one of a row of customers' men's desks along the back of the room, facing the board. In front of them were two dozen leather armchairs in which lounged eight or ten customers, some of them pretty seedy-looking. *Sotto voce*, Humphrey explained that every broker's office has its quota of such hangers-on, mostly speculators who like to sit and stare at the ticker, swap tips, and chomp their cigars.

Recommended Issues

For Dr. Shafer's approval, Humphrey produced a list of six stocks recommended by the New York office. All were dividend payers, offering an average yield of just under 5 per cent. An accompanying report briefly described the business, operating prospects, and financial characteristics of each company. The doctor decided to start with the purchase of twenty-five shares of Mon-

santo Chemical. The board showed the last sale had been at 95⅝.

"Shall we make it a market order?" asked Humphrey.

"Come again?" said the doctor.

How to Order

The other explained that there were three kinds of orders: (a) market, (b) limit, and (c) stop-loss:

A *market order*, either to buy or sell, instructs the broker to act at once, at the best price he can get.

A *limit order*, either to buy or sell, names a specific price. For example, a customer may like a stock selling at 95, but feel the price is about $5 too high. So he puts in a limit order to buy at 90. His order is executed when and if the stock declines to 90. Conversely, already owning the stock, he may decide it should be sold if it goes $5 higher. So he puts in a limit order to sell at 100. The order is executed when and if the deal can be made at this figure.

A *stop-loss order* (to sell, if the customer already owns the stock; to buy, if he has previously sold the stock short*) gives him automatic protection against a decline (if he's long of the stock) or a rise (if he's short) of more than a specified number of points.

*Selling a stock short—a highly speculative procedure—means selling shares you don't own, in the hope that you can buy them back later at a lower figure. It is thus a method of betting that the price of the stock will decline. When you sell a stock short, your broker borrows the shares from another customer and delivers them in your behalf to the buyer. Sooner or later, you've got to buy enough shares to repay the lender.

"For instance," said Humphrey, "suppose you already had your Monsanto. You bought it at 95 and now it's almost down to 90. You're afraid it *could* go lower, and want to limit yourself to a five-point loss at most. So you put in a stop-loss sell order at 90. If the stock hits that figure, your sale is executed at the best price immediately available thereafter, which might be 90 or a fraction under or above it."

"Suppose it hits 90 and my stop-loss sell order is executed," said Dr. Shafer, "and then the stock bounces back up to 95?"

"That would be your tough luck as a speculator. And you would be speculating, of course. Actually, as an investor buying for the long pull, without much concern for the intermediate ups and downs, you'll probably never have occasion to use a stop order."

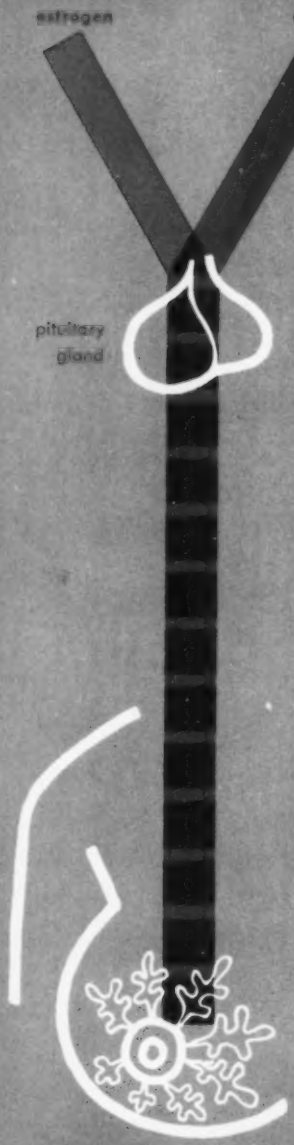
'Execute It Now'

He went on to explain that limit and stop orders could stand as long as the customer wanted them to—a day, a week, a month, or "GTC" (good till canceled). "However, most of your orders will probably be market orders, to be executed at once."

The doctor looked dubious. "I don't know about placing an order without knowing exactly what I'm going to pay. What if Monsanto jumps to 100 on the next sale?"

"Not a chance. We'll get a quote on it right now." [MORE ON 204]

"Premarin" with Methyltestosterone effectively suppressed postpartum breast engorgement and lactation with virtually no side effects in 96.2 per cent of a series of 267 patients.*



Treatment of postpartum breast engorgement with "Premarin" with Methyltestosterone "was fully effective in 96.2 per cent of cases."*

Fiskio reports complete control in 166 patients, good results in 91, and fair in 10 patients. No failures were noted. Short duration therapy was employed, starting immediately on the patient's return from the delivery room, usually about 45 minutes after delivery.

None of the following symptoms occurred: nausea, vomiting, breast abscess, excessive lochia, withdrawal bleeding, virilization.

Menstruation was re-established after a normal interval of about six weeks.*

*Fiskio, P. W.: GP *11*:70 (May) 1955.

The inhibitory action of combined estrogen and androgen on the pituitary lactogenic hormone is greater than the effect of either steroid employed alone.

In addition

Postpartum depression was notably absent.

In his series of 267 patients, Fiskio* noted as a particular advantage of "Premarin" with Methyltestosterone therapy the absence of mental depression in the puerperium.

Postpartum depression is believed to be brought about by the abrupt decline in estrogen levels and, therefore, responds to substitution therapy. Androgen serves to enhance the feeling of well-being.

Suggested Dosages

Some clinicians recommend intensive short duration therapy while others advocate lower dosage levels extending over a longer period of time. In either case, it is important to start therapy as soon as possible after delivery.

Short duration therapy (one week)
3 tablets (yellow) every four hours for five doses; then 2 tablets daily for balance of week.

"Step-down" therapy (10 to 15 days)
1st day — 4 tablets (yellow) in divided doses;
2nd day — 3 tablets (yellow) in divided doses;
3rd day — 2 tablets (yellow) in divided doses;
subsequently — 1 tablet (yellow) daily.
Treatment is continued for 10 to 15 days.

Ayerst Laboratories • New York, N. Y. • Montreal, Canada

"Premarin" with Methyltestosterone effectively inhibits lactation and "seems to have small capacity to induce withdrawal bleeding, the most dangerous side-effect of the usual lactation-inhibiting drugs."

Wilson, T. M.: M. Ann. District of Columbia 23:489 (Sept.) 1954.

Many clinicians favor the use of estrogen and androgen as combined in "Premarin" with Methyltestosterone,

1) because of the additive effect of the two steroids in inhibiting the pituitary lactogenic hormone,

2) because therapeutic control is usually achieved without undesirable side effects such as nausea and vomiting, excessive lochia, withdrawal bleeding, recurrence of engorgement, and virilization.

Other Indications

"Premarin" with Methyltestosterone is also indicated in osteoporosis, dysmenorrhea, climacteric (female and male) in certain cases, malnutrition (in the female), and as an adjunct to treatment with cortisone in rheumatoid arthritis.

SUPPLIED IN TWO POTENCIES: the *yellow* tablet (No. 879) contains 1.25 mg. of conjugated estrogens (equine) and 10 mg. of methyltestosterone; the *red* tablet (No. 878) contains 0.625 mg. and 5 mg. respectively. Both potencies are available in bottles of 100 and 1,000 tablets.

"PREMARIN"® with METHYLTESTOSTERONE

ideal preparation for combined estrogen-androgen therapy

5323

Malpractice Postscripts

What's your best buy in malpractice insurance? The May* MEDICAL ECONOMICS *gave you some answers. Now here's informed comment on our article from members of malpractice committees, lawyers with malpractice experience, and other interested parties. Their remarks shed new light on the finer points—beginning with the key question, 'How much coverage?'

● *We said:* "Find out all you can about malpractice awards in your area. Establish your limits of coverage in the light of these awards, not in the light of preliminary claims. Set the limits at a level that will give you reasonable peace of mind . . . 'The lowest limits appropriate to your specialty and location' are every doctor's best buy."

P.S. from W. Clifford Klenk, an insurance consultant in New York City: After reviewing the professional liability problems of more than 500 physicians, I'm convinced that $10,000 coverage is adequate for most general practitioners in this area. Juries aren't hitting them for any more than that.

In certain sensitive specialties—eye surgery, for example—coverage up to $50,000 may be justified. As a rule, though, lower limits are best. That's been the almost universal experience of the doctors I've worked with.

• • •

P.S. from Dr. James Basil Hall, Mount Dora, Fla.: We in the local medical profession have been studying the question, "How much coverage?" There seems to be

for your tense peptic ulcer patients

new
ANTRENYL®-PHENOBARBITAL

depresses... ...gastrointestinal motility

...gastric acid secretion

...nervousness and irritability so common in the ulcer diathesis

SUPPLIED: Antrenyl-Phenobarbital Tablets (scored), each tablet containing 5 mg. Antrenyl and 15 mg. phenobarbital.

Other forms: Tablets, 5 mg. Syrup, 5 mg. per 4-ml. teaspoonful. Pediatric Drops, 1 mg. per drop.

Antrenyl® bromide (oxyphenonium bromide CIBA)

agreement that, on a national basis, we should get together on the amount of insurance to be carried.

We feel that a happy medium somewhere between $25,000 and $75,000 might be about right.

• • •

P.S. from Dr. Thomas M. D'Angelo, Jackson Heights, N.Y.: You reported that one Manhattan ophthalmologist, a member of his society's special malpractice committee, had $5,000 coverage. I believe that's much too low.

I'd recommend at least $50,000 and maybe $100,000 in his case. The cost of the additional coverage amounts to relatively little.

• • •

P.S. from Howard Hassard, San Francisco attorney: Low limits certainly aren't safe here. The idea that plaintiffs' attorneys will "lay off" or settle cheap because of low insurance simply doesn't accord with my experience. Plaintiffs' lawyers, including the Mr. Belli you mentioned, have sued and will continue to sue doctors who are underinsured.

Our office has defended quite a few physicians in cases where Mr. Belli has represented the plaintiff. I assure you that he hasn't let up one bit merely because the physician didn't carry much insurance.

The same goes for the attitude of jurors. They've seen too many physician-driven Cadillacs to shed tears over the possibility that a verdict may be in excess of the doctor's insurance.

If you'd ever had the experience of representing physicians who were sued for large sums of money while inadequately insured, you'd understand the terror and fear and anxiety that the doctor goes through. I've had physicians' wives call me and ask whether they dared purchase some much-needed new furnishings for their homes; a lawsuit was pending against the doctor, and his insurance was either small or nil.

It simply isn't worth going through for *any* reason.

• • •

P.S. from a malpractice committee member in Oakland, Calif.: I've seen underinsured physicians become not only mentally disturbed but physically ill when served with a suit for high damages.

The underinsured physician is not only a hazard to himself; he's a hazard to the whole local profession. If a large claim is brought against him, he wants to settle it at any cost within the limits of his coverage. Thus, claims are paid in some cases that are perfectly defensible. And that raises everyone's premiums.

• • •

P.S. from Clayton L. Scroggins, a medical management consultant in Cincinnati: No mention is made of what coverage is fair from the standpoint of the patient. Suppose there has been malpractice—beyond the control of the doctor, perhaps, but malpractice nevertheless. Suppose a severe disability has resulted. Will "the lowest limits appropriate to

your specialty and location" provide enough recompense for a permanent injury or a disfigurement for life?

Certainly, if a doctor causes the permanent paralysis of a child, he won't be satisfied to have the patient receive only $5,000. Many doctors I know prefer to carry enough insurance so that, in the event of their error, the person damaged will be compensated fairly.

What Price Coverage?

We said: "You're confronted with a dwindling choice of policies at steadily rising rates . . . Throughout the country, doctors insured individually by the big stock insurance companies are paying an average of 35 per cent more this year . . . Your best buy in malpractice insurance, therefore, can't be measured by present premiums alone . . ."

P.S. from Dean E. Nusbaum, the Nettleship Company, Los Angeles: Our experience started with the Los Angeles County Medical Association thirteen years ago. It has been necessary to increase premiums from time to time. But you will be interested to know that on Jan. 1, 1955, we were able to make a modest reduction of 5 per cent in the premium. We are hopeful that further downward adjustments can be made in the future.

* * *

P.S. from Dr. John F. Kelley,

Gastric Hyperacidity: etiology

People being people, environmental factors contributory to gastric hyperacidity are hard to remove, even when their role is clearly defined. But, the physician has a sure, simple—even pleasant—way of relieving the acid distress caused by:

- dietary indiscretion
- nervous tension
- emotional stress
- food intolerances
- excessive smoking
- alcoholic beverages

Gelusil promptly and effectively controls the excessive gastric acidity of "heartburn" and chronic indigestion. And it affords equally rapid relief in peptic ulcer. Sustained action is assured by combining magnesium trisilicate with the specially prepared aluminum hydroxide gel.

Free from constipation: Gelusil's aluminum hydroxide component is specially prepared: the concentration of aluminum ions is accordingly low; hence the formation of astringent—and constipating—aluminum chloride is minimal.

Free from acid rebound: Unlike soluble alkalies, Gelusil does not over-neutralize or alkalinize. It maintains the gastric pH in a mildly acid range—that of maximum physiologic functioning.

Dosage—2 tablets or 2 teaspoonfuls two hours after eating or when symptoms are pronounced. Each tablet or teaspoonful provides: 7½ gr. magnesium trisilicate and 4 gr. aluminum hydroxide gel.

Available—Gelusil Tablets in packages of 50, 100, 1000 and 5000. Gelusil Liquid in bottles of 6 and 12 fluidounces.

Gelusil®

Antacid • Adsorbent

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NOW

a new Robins' Extentab for

"all-day" or "all-night"

SEDATIVE THERAPY

on single tablet dosage

Phenobarbital—the sedative par excellence—is now available in the unique Robins' Extentabs dosage form, as 'Stental Extentabs'.

Each Stental Extentab contains ¼ gr. phenobarbital, one-third of which is released promptly on ingestion, and the balance gradually and evenly, to provide smooth, sustained sedation over a period of 10 to 12 hours... thus avoiding repeated dosage during the day, or awakening at night for additional medication.

Robins

STENTAL EXTENTABS

(Phenobarbital Extended Action Tablets)

EXTENTABS

A. H. ROBINS CO., INC. • Richmond 20, Virginia

Ethical Pharmaceuticals of Merit since 1878

Utica, N.Y.: There's some evidence that malpractice rates under the New York State group plan are now leveling off. It's already been decided, for example, that premiums will remain the same through September, 1956, at least.

• • •

P.S. from Dr. Charles L. Farrell, Pawtucket, R.I.: All such policies are costly and will probably become even more so. But in my opinion, too much emphasis has been placed on the cost.

Malpractice premiums are a necessary expense of medical practice. As such, they're fully tax-deductible. Thus the cost is unimportant compared with the protection afforded.

Whatever the best protection costs, it's worth it.

Carrier's Experience

We said: "Narrow your choice to the carriers with the best recent records . . . If no one malpractice plan provides everything you want, consider taking out policies with *two* different carriers . . ."

P.S. from the publicity director of a malpractice insurance company in the Midwest: It usually requires at least five years to get an underwriting experience that reflects, with any semblance of accuracy, the proper premium charge to cover the liabilities incurred.

The premiums that a company collects are intended to cover liabilities resulting from professional services rendered that same year. But there are delays in the filing of suits; there are delays in the trial of suits. And there are cases where the cause of injury (e.g., overlooked sponges) may not be discovered for years. Thus the final insuring cost for any given year doesn't become known until a long time after the premiums are collected.

We have handled suits that have arisen as long as forty-six years after the services were rendered. Less experienced companies, which usually fail to give due regard to this lag, wake up to their error when it is too late to correct it without losing the business.

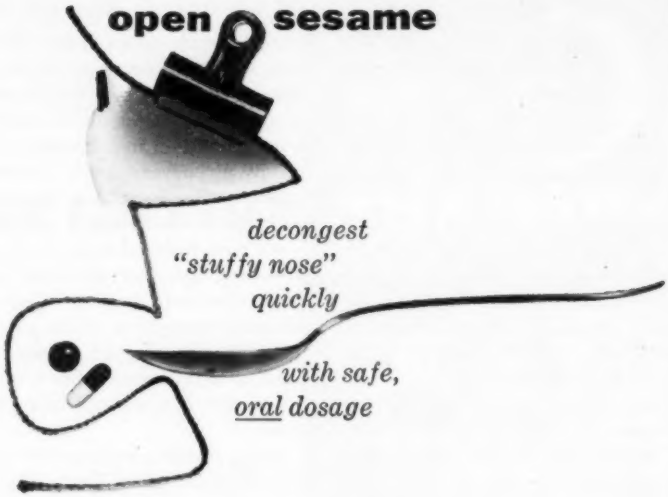
As for carrying policies with two or more companies: That's a good way of keeping more companies in the field and thus assuring competition. Without competition, in fact, there is no best buy.

Package Deals

We said: "Without tie-in sales, some big stock companies won't write malpractice insurance any more. Many an M.D. has complained about this . . ."

P.S. from A. W. Waite, the Aetna Casualty and Surety Company, Hartford, Conn.: Your statements regarding "tie-in sales" should be modified or explained. I quote from instructions sent to our field offices about the middle of 1954:

"The Aetna has been engaged in writing this class of business some forty years, and today is one of the largest writers. We appreciate the



Novahistine®

ELIXIR/TABLETS/FORTIS CAPSULES

Oral use of this synergistic combination of vasoconstrictor and antihistamine takes the "sting" out of decongestion... eliminates risks of improperly used topical agents. And, Novahistine causes no jitters, insomnia, or drug tolerance.

Each Novahistine Tablet, or teaspoonful of Elixir, provides 5.0 mg. phenylephrine hydrochloride and 12.5 mg. prophenpyridamine maleate. In NOVAHISTINE *Fortis* Capsules the phenylephrine content is doubled, for patients needing greater vasoconstrictive effect.

PITMAN · MOORE COMPANY
DIVISION OF ALLIED LABORATORIES
INDIANAPOLIS, INDIANA

fact that professional coverage is vitally essential to the ethical practitioner of medicine and surgery. Since this coverage has been highly unprofitable, we came to the conclusion that, rather than stop writing it, we would establish the following underwriting program which we hope will enable us to carry on:

"1. Professional liability coverage . . . will be handled only when the risk comes to us through a regularly licensed agent of our company. We . . . do not feel we should be expected to accommodate brokers who offer us only this line of business . . .

"2. As to physicians and surgeons now insured with us through licensed Aetna agents, we are willing to renew their professional liability coverage, regardless of whether or not they carry any other lines of insurance with us at this time. It is, of course, only natural that our agent, in his desire to be of service in rounding out his client's insurance needs, will be asking his doctor-client if he has other protection he might now write . . .

"3. As respects doctors not presently insured with us, we are willing to provide professional liability protection through an Aetna agent in such cases where our agent is also favored with a reasonable portion of the doctor's more desirable lines . . .

"This underwriting policy should not . . . be considered as a 'tie-in'

sales program, but a program designed to accommodate and round out the various insurance needs of our professional clientele . . ."

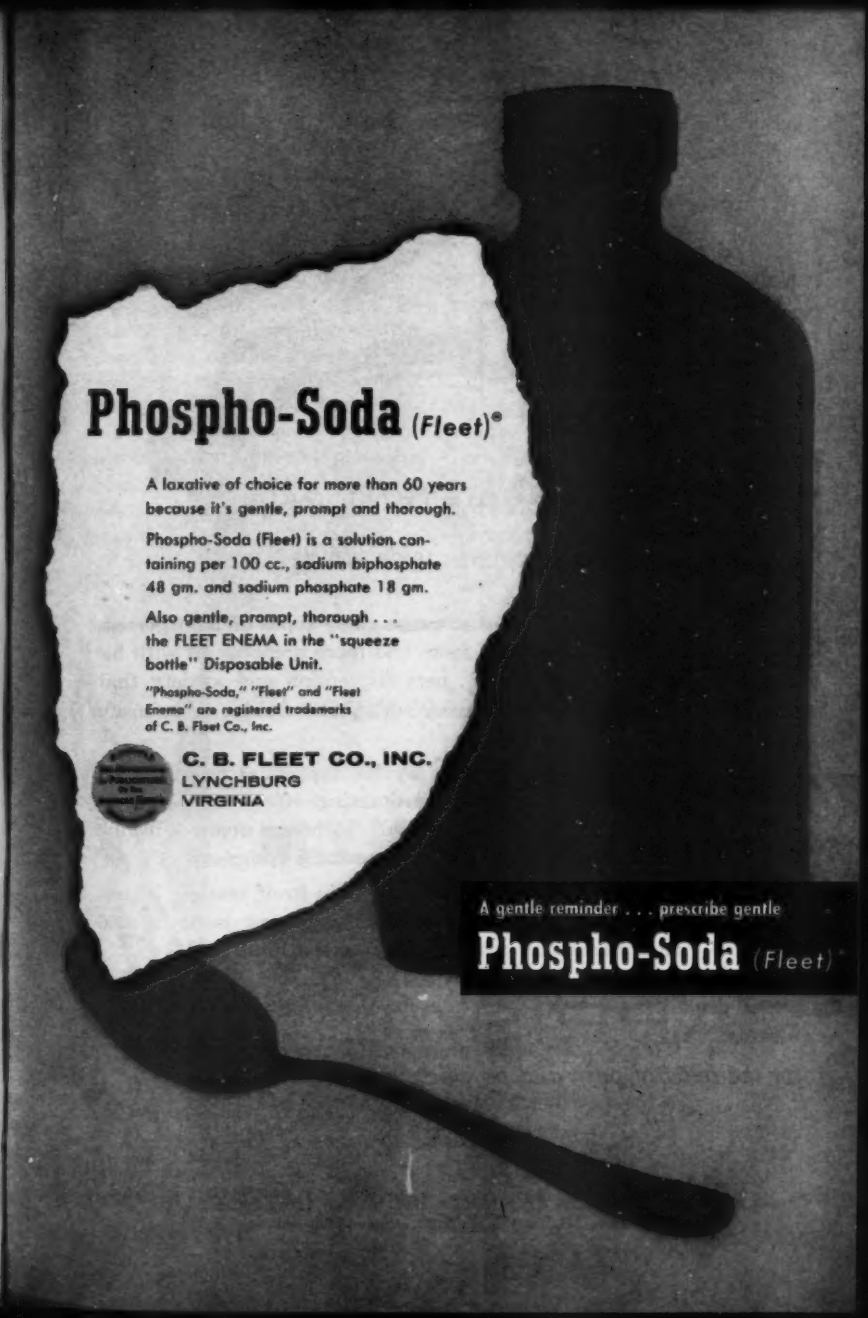
Foreign Competition

We said: "Much more willing to accept bad risks are the big foreign insurance companies—notably, Lloyd's of London . . . The big question about foreign insurers is not, as a rule, their integrity. It's whether their experience has prepared them properly for the American malpractice market . . ."

P.S. from Howard Hassard, San Francisco attorney: The functioning of Lloyd's underwriters needs to be better understood. Lloyd's of London is not an insurance company; it is a place. There are hundreds of individual underwriters who effect insurance under the name and at the place called "Lloyd's London." Each policy issued through Lloyd's is actually a contract made jointly by two or more—usually hundreds—of these individual underwriters.

My own investigation of the past two years has indicated that a great many "Lloyd's" policies issued in this country are not underwritten primarily by Lloyd's underwriters at all. They are underwritten by various British or European insurance companies, with underwriters at Lloyd's London taking "excess coverage" only.

The British and European companies involved are of unknown financial stability. They certainly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A laxative of choice for more than 60 years because it's gentle, prompt and thorough.
Phospho-Soda (Fleet) is a solution containing per 100 cc., sodium biphosphate 48 gm. and sodium phosphate 18 gm.
Also gentle, prompt, thorough . . . the FLEET ENEMA in the "squeeze bottle" Disposable Unit.
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A gentle reminder . . . prescribe gentle
Phospho-Soda (Fleet)®

3 TYPES OF PERSISTENT PAIN

with** psychic **side effects

As the conditions that cause these types of pain persist, the patient becomes more and more preoccupied with his pain. The depression, nervous tension and anxiety that nearly always accompany such pain combine to intensify and prolong it.

'Daprisal' relieves these psychic aspects of pain because it provides the mood-ameliorating effect of Dexamyl* (Dexedrine† and amobarbital). It brings about a feeling of energy and well-being, and restores optimism.

'Daprisal' works to relieve the pain itself because it provides the combined analgesic effect of acetylsalicylic acid and phenacetin, *potentiated* by amobarbital.

DAPRISAL*

for the relief of pain and psychic side effects of pain

Smith, Kline & French Laboratories, Philadelphia 1

*T.M. Reg. U.S. Pat. Off.
†T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

have no goodwill to protect in the U.S. I think this is one subject that deserves further research.

Settle or Fight?

We said: "When you buy malpractice insurance, you want more than dollar protection. You want defense of your professional reputation as well. Yet some malpractice plans seem to specialize in 'nuisance settlements,' which seldom do the doctor's reputation any good . . . Probably the best malpractice plans are those that inhibit both the insurer *and the insured* from settling too easily . . ."

P.S. from Dr. George A. Unfug, Pueblo, Colo.: I would stress the importance of requiring all member physicians to report suits or threatened suits to their state medical society. I think that rules with teeth in them, requiring state society permission before suits could be settled out of court should be a part of every state society's procedure. We've got such rules in Colorado.

• • •

P.S. from Dr. George S. Klump, Williamsport, Pa.: Here's the best way to keep malpractice costs down: Turn the defense over to county and state medical societies, in cooperation with the insurance company involved. And never agree to an out-of-court settlement in a defensible case.

[MORE ▶

MALPRACTICE

That's the way we do it in Pennsylvania. As a result, we have perhaps the lowest malpractice rates in the country.

A Pennsylvania doctor who is sued is privileged to seek approval of the Board of Censors. He signs an agreement that he *will not consent to a settlement* to keep himself out of court. He has his choice of counsel—who, however, must work with others provided. He gets the finest cooperation from Medical Protective. It's a fighting company!

During my ten years as an officer of the state medical society, there wasn't a single court judgment against any doctor in my district.

• • •

P.S. from Dean E. Nusbaum, the Nettleship Company, Los Angeles: The question is often asked why insurance companies do not defend all

NEW—for weight gain—
high-calorie food supplement

MorCal*

TRADEMARK

with B_1 and B_{12}

won't be just "tolerated" by your underweights...they'll love it!

adds variety, doesn't satiate

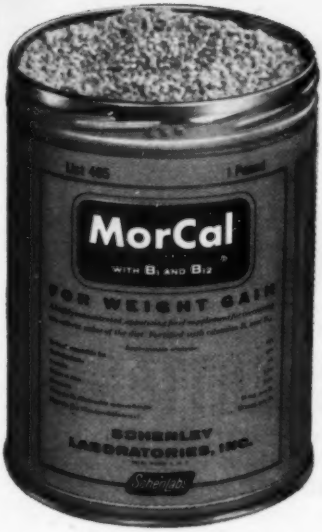
MorCal provides a new, pleasant way to add taste-tempting variety to the weight-gain diet. It's delicious "as is," or topped with fruit and milk for breakfast or between-meal snacks. Cereal-like MorCal can be added to or mixed with almost any food on your patients' menus. This new fat preparation doesn't satiate, leaves no cloying aftertaste.

easy to use in cooking or baking

MorCal can be used as a substitute for most of the flour in cooking and baking, often increasing calorie content 30 to 100 per cent. It adds flavor as well as calories to desserts, soups, gravies, sauces, etc.

prescribe MorCal

for overactive, fast-growing youngsters, underweight adults, convalescents, the chronically ill, and elderly patients. Just two rounded tablespoonfuls four times daily (120 grams) add 720 extra calories to the diet—plus 12½ times the minimum daily requirement of vitamin B_1 and 6½ times the suggested daily supplement of vitamin B_{12}.



Request booklet for patients

Special MorCal recipe booklet

shows your patients many taste-tempting ways to add calories and variety to their weight-gain diet. Prepared by our home economics consultant, this "Recipes and Uses" booklet is enclosed above the inner seal of each one-pound tin of MorCal. A supply of these recipe booklets is yours for the asking—just let us know how many you require to give to your patients.

MorCal contains refined vegetable fat 44%, carbohydrate 42%, protein 9%, mineral ash 2.5%, moisture 2.5%, vitamin B_1 (thiamine mononitrate) 50 mg. per lb., and vitamin B_{12} (cyanocobalamine) 50 mcg. per lb. MorCal is prepared from hydrogenated cottonseed oil, proteins and carbohydrates from dried skim milk solids and wheat flour, natural flavorings, synthetic vitamins B_1 and B_{12}.

*MORCAL IS SCHENLEY LABORATORIES' TRADEMARK FOR A HIGH-CALORIE FOOD SUPPLEMENT. PATENT PENDING.

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for otitis

'AEROSPORIN'® SULFATE

POLYMYXIN B SULFATE WITH PROPYLENE GLYCOL

OTIC SOLUTION STERILE

Specifically aimed at aural pathogens—

bactericidal to most gram-positive and gram-negative organisms, particularly *Ps. aeruginosa*, the commonest cause of otitis externa.

fungicidal to most of the dermatomyces found in the ear.

For otitis externa, whether acute or chronic, an exceptionally high percentage of complete clearance in a short time.

For chronic otitis media (when the ear drum is perforated); preferably in conjunction with systemic therapy.

Bottles of 10 cc. (with dropper)

Burroughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe 7, New York

claims and suits alleging malpractice against the doctor. The basis of the question seems to be a misapprehension that all malpractice cases are defensible. They're not!

Defense is almost impossible, for example, in the category known legally as *res ipsa loquitur*—"the act speaks for itself." A diathermy burn, or a hemostat left in a patient, may fall in this category. Very few of these cases can be defended.

Defense is almost impossible, too, in some orthopedic cases where a bad result has been obtained. And defense is extremely difficult where the doctor would make a poor witness. (Example: the doctor who becomes antagonistic when the propriety of his acts is questioned.)

There are other reasons why the defense of a case can be dangerous. The attendant newspaper publicity may damage the whole local profession. Experience shows that whenever a court judgment of some size is awarded, several similar claims or suits will be filed almost immediately thereafter.

Then there's the effect on the defendant doctor to think about. Recently, for example, a case had to be settled before trial: The doctor had suffered a heart attack and couldn't stand the strain of a court appearance.

A study some time ago showed that 53 per cent of the claims made against doctors were resolved with neither a trial nor a settlement. Of the remaining 47 per cent, about half were tried and about half settled. The bulk of the cases that were settled were settled because malpractice had actually occurred, or because the doctor's records were inadequate to disprove the plaintiff's claims, or because the dangers of defense were too great for the risk of a trial.

Lawyers to Blame?

We said: "Liability lawyers have pushed this new idea [of suing for astronomical sums] vigorously. Why not? Their fees are contingent on court awards . . ."

P.S. from Dr. Lyon Steine, Valley Stream, N.Y.: I am of the firm conviction that we doctors have been played for a bunch of suckers by the legal profession.

The great trouble with malpractice suits is that they're tried under laws enacted by legislators (most of whom are lawyers) and interpreted by judges (all lawyers). No wonder we doctors have trouble!

It happens frequently enough that a physician is unjustifiably convicted of malpractice because his attorney was careless, negligent, or ignorant of the law. Can the doctor sue his attorney for malpractice? It happens sometimes that a physician is convicted because of an improper charge to the jury by the presiding judge. Can the doctor sue the judge for malpractice?

Why shouldn't these men be required to meet some standard of legal practice, with failure to meet it

constituting professional negligence? And why shouldn't it be unethical for plaintiffs' lawyers to have a monetary interest in the amount of the verdict?

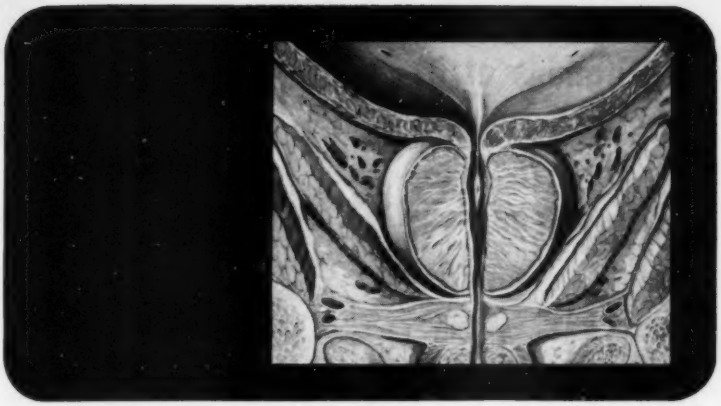
In Canada, where I hail from, there is a legal institution known as "costs of court." It's a respectably sized penalty paid by the loser in a court action, and it's a good antidote for "nuisance suits." The idea might well be enlarged upon here, perhaps along the lines suggested recently in the New York Herald Tribune by John S. Newstead. He wrote:

"In my humble view, too many lawyers are accepting clients' claims for court action with a notorious lack of solid foundation because the suing parties don't risk anything.

"In many countries, [when] a lawsuit is lost, the losing party has not only to pay the court expenses, but also the fees for the opponent's lawyer. If in the United States we would adopt a similar system . . . you'd be surprised how the caravan of lawsuit-happy claimants would dwindle . . ."

* * *

P.S. from Dr. Carl M. Hadley, San Bernardino, Calif: The legal profession must somehow be induced to take action against those attorneys who are prosecuting meritless claims on a contingency basis. I think this is probably one of the most frequent causes of suits. Our



acute and chronic

prostatitis...

76.6% cured or improved with

Furadantin®

brand of nitrofurantoin, Eaton

137 cases of prostatitis were treated with Furadantin with the following results:

	Acute prostatitis	Chronic prostatitis	Total
No. cases	20	117	137
Cured	15	30	45
Improved	4	56	60
Failed	1	31	32

(Personal communications to the Medical Department, Eaton Laboratories.)

Furadantin has a wide antibacterial range

Furadantin is effective against the majority of gram-positive and gram-negative urinary tract invaders, including bacteria notorious for their resistance. Furadantin is not related to the sulfonamides, penicillin or the 'mycins.

With Furadantin there is no blood dyscrasia...no proctitis...no pruritus ani... no crystalluria...no moniliasis...no staphylococcic enteritis.

Furadantin tablets—50 and 100 mg., bottles of 25 and 100. Furadantin Oral Suspension (5 mg. per cc.)—bottle of 4 fl.oz. (118 cc.).

EATON LABORATORIES

NORWICH • NEW YORK

THE NITROFURANS—A UNIQUE CLASS OF ANTIMICROBIALS PRODUCTS OF EATON RESEARCH

society has even considered entering counter-suits in such cases.

• • •

P.S. from Dr. George A. Unfug, Pueblo, Colo.: From limited personal experience as an expert witness, I have concluded that the attorneys retained by insurance carriers are not always sufficiently interested in preparing an adequate defense of the defendant physician.

I know this to be true in one case where the patient was awarded damages in a lower court. At the insistence of the defendant physician, the case was carried to the supreme court of the state. There the decision of the lower court was reversed.

I think this problem should be called to the attention of the insurance carriers. There seems to be little awareness of it.

When Doctors Criticize

We said: "Don't switch malpractice plans before comparing what they do to prevent claims . . . Prevention means making doctors conscious of what causes claims. A prime cause is 'careless statements by some physicians about their colleagues'. . . professional skill'. . ."

P.S. from Dr. Herbert P. Ramsey, Washington, D.C.: It's amazing to hear some physicians sound off about other physicians. They're always ready to make an off-the-cuff pronunciamento about the other doctor's treatment, even though they lack all the information their colleague had. [MORE▶

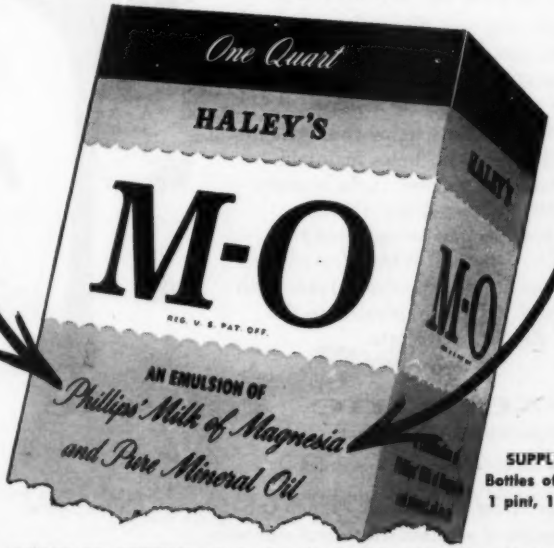
Smooth-Working Combination

TO HELP CORRECT CONSTIPATION

Antacid • Laxative • Lubricant

Magnesium Hydroxide plus pure mineral oil make Haley's M-O a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and the attendant gastric hyperacidity.

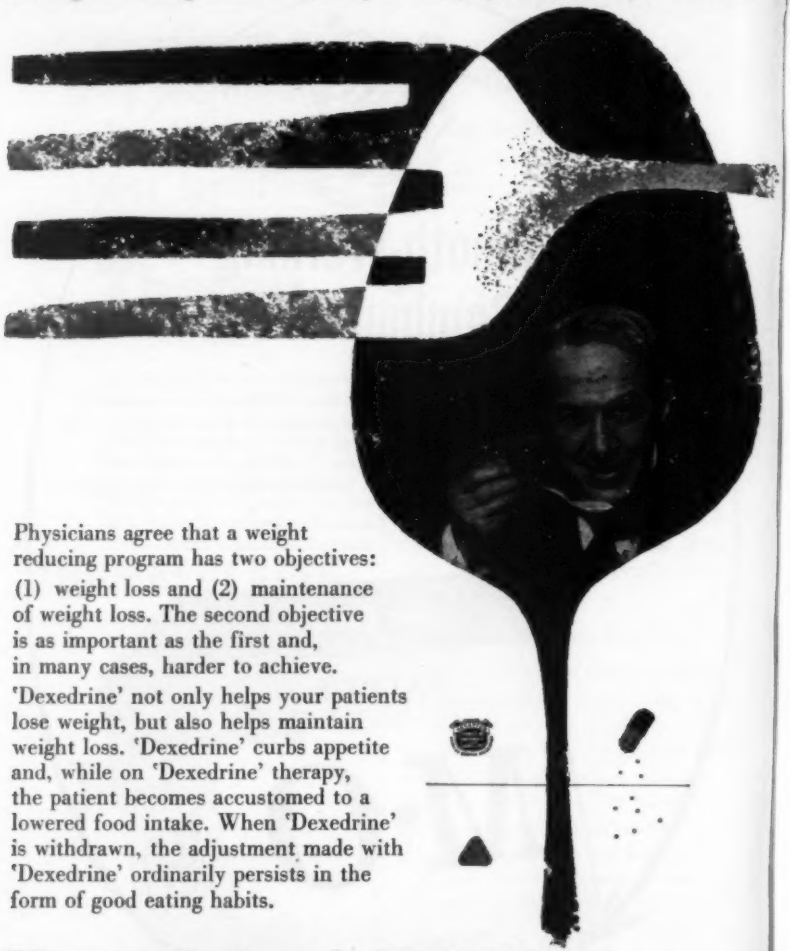
The oil globules in Haley's M-O are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is avoided and a comfortable evacuation is effected through stimulation of normal intestinal rhythm and blunted defecation reflex.



SUPPLIED:
Bottles of 8 oz., 1 pint, 1 quart.

THE CHAS. H. PHILLIPS CO. DIVISION *of Sterling Drug Inc.* **1450 Broadway, New York 18, N. Y.**

creating new eating habits is the way to ensure permanent weight reduction



Physicians agree that a weight reducing program has two objectives: (1) weight loss and (2) maintenance of weight loss. The second objective is as important as the first and, in many cases, harder to achieve.

'Dexedrine' not only helps your patients lose weight, but also helps maintain weight loss. 'Dexedrine' curbs appetite and, while on 'Dexedrine' therapy, the patient becomes accustomed to a lowered food intake. When 'Dexedrine' is withdrawn, the adjustment made with 'Dexedrine' ordinarily persists in the form of good eating habits.

Dexedrine* Sulfate

dextro-amphetamine sulfate, S.K.F.

Tablets • Elixir • Spansule† capsules

made only by Smith, Kline & French Laboratories, Philadelphia
the originators of sustained release oral medication

*T.M. Reg. U.S. Pat. Off. Patent Applied For.
†T.M. Reg. U.S. Pat. Off. for S.K.F.'s brand of sustained release capsules.

Before sounding off, these men had better ask themselves: "Could this be twisted into a meaning which might form the basis of a malpractice suit?"

• • •

P.S. from Dr. Alfred A. J. Den, Washington, D.C.: The resident and interne staffs of our hospitals can stand considerable improvement on this score. Too often they make unfortunate remarks about the patient's prior treatment by some outside doctor.

They need to be made more conscious of the malpractice problems they stir up.

• • •

P.S. from Dr. Solomon Schussheim, Brooklyn, N.Y.: We need to impress upon the large medical centers and their staffs that physicians

"How come the masks? So no one will know who's to blame if the operation's a failure?"

not connected with their institutions are honest, able, conscientious men. We also need to cut out loose talk in front of patients by our nurses and office help.

The Surest Safeguard

We said: "Even a doctor's *attitude* can make him a bad risk . . ."

P.S. from Dr. Samuel M. Day, Jacksonville, Fla.: What can we, as individuals, do for our protection? It would be best for us to "forget" we have malpractice insurance—to treat each patient as though nothing protected us from suits except our own skill and conscience.

• • •

P.S. from Dr. Vincent T. Williams, Kansas City, Mo.: How can we conduct our practices so as to reduce the total number of malpractice claims? The best thing we can all do is to "run scared," as the politicians say. Here's how I explain this to my medical students:

Treat every case as if it were a potential lawsuit. Before dismissing any patient, ask yourself: "Have I done everything for him that's customary in treating this condition? Have I recorded it so that I could prove on the witness stand that I wasn't negligent?"

If you think of these questions every time—and answer them affirmatively—you'll never be sued successfully for malpractice. END

NOW! PROVE TO YOURSELF:

Here's a Whole Protein Supplement THAT TASTES AS GOOD AS ICE CREAM!

MORE NUTRITIOUS THAN EGGNOG . . . AND COSTS *LESS* TO SERVE!

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WHOLE PROTEIN SUPPLEMENT

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Compare the nutritive value of Meritene vs. Eggnog

	8 oz. EGGNOG*	8 oz. MERITENE MILK SHAKE
Protein	14.6 gm.	17.9 gm.
Fat	13.0 gm.	9.5 gm.
Carbohydrate	24.7 gm.	28.6 gm.
Iron	1.5 mg.	4.46 mg.
Calcium	.31 gm.	.58 gm.
Phosphorus	.33 gm.	.46 gm.
Vitamin A	940 I.U.	2380 I.U.
Thiamine	.14 mg.	.77 mg.
Riboflavin	.56 mg.	1.64 mg.
Ascorbic Acid	3.0 mg.	23.7 mg.
Vitamin D	31 I.U.	161 I.U.
Cholesterol	299 mg.	38.4 mg.
Calories	291 mg.	270

Meritene Milk Shake costs 1 to 4¢ less per serving than eggnog

*Nutritive value of Eggnog from Bowes and Church, 7th Ed. 1951.

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Available at all drugstores in plain or chocolate flavors. 1 lb. can—$1.69; 5 lb. can—$7.74.

MERITENE mixes with milk in seconds (and *stays* mixed) to provide ideal between-meal nourishment for hospital and convalescent patients. One eight-ounce serving of MERITENE Milk Shake provides over one-quarter the N.R.C. Daily Dietary Allowances for the average active man in protein and all the essential vitamins and minerals. Have a MERITENE Milk Shake at our expense—just mail the coupon below—and prove to yourself that MERITENE is a high protein supplement that actually *tastes good!*

HAVE YOU TASTED MERITENE?

FREE ONE-POUND SAMPLE available, plus a supply of these comprehensive MERITENE Diet Sheets: • Diabetic Diet • High Caloric diet (3585 calories) • 2000 Calorie Diet with restricted sodium content • Bland Low-Cellulose Diet • Ulcer Diet • Diet for diseases of the Liver.

CLIP AND MAIL FOR FREE SAMPLE ME 75

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Because of customs regulations, offer limited to U.S.

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...specifics in diarrhea

The RESIONS offer two effective compounds for treatment of almost any diarrheal condition found in clinical practice.

The RESIONS act by ion exchange . . . to attract, bind and remove toxic materials in diarrheas caused by food or bacterial toxins; by prolonged use of certain drugs, and in general infectious diseases.

The RESIONS *are safe* because they are totally insoluble and non-toxic.

RESION therapy will control about 90% of common diarrheas.

RESION P-M-S is intended specifically for rapid control of those rare diarrheas caused by Gram-negative organisms; to prevent secondary bacterial infection; in mycotic diarrhea following the use of the broad-spectrum antibiotics, and to inhibit the enteric growth of *C. albicans* (Monilia).

Resion

time-tested, adsorbent effectiveness

Polyamine methylene resin	10%
Sodium aluminum silicate	10%
Magnesium aluminum silicate	1.25%

CONGO MAGIC
(Dysentery Fetish)

RESION therapy now works scientific magic against diarrhea.

and

Resion P-M-S

A new formula providing antibacterials to combat bacillary and fungal vectors

NATIONAL

Each 15 cc. contains the RESION formula plus:

Polymyxin-B sulfate	125,000 units
Phthalylsulfacetamide	1.0 Gm.
Para hydroxybenzoic acid esters	0.235 Gm.

Dosage: RESION—1 tablespoonful hourly for 4 doses; then every 3 hours while awake. RESION P-M-S—1 tablespoonful hourly for 3 doses; then 3 times daily.

Supplied: RESION, in bottles of 4 and 12 fluid ounces. RESION P-M-S, bottles of 4 fl. oz.

THE NATIONAL DRUG COMPANY
Philadelphia 44, Pa.

How's Your Insurance Quotient?

To understand your own insurance, you've got to grapple with the language of the insurance men. Test your 'I.Q.' by means of this checklist of forty basic terms. If you're already familiar with thirty-five of them, you're above average

By Bion H. Francis

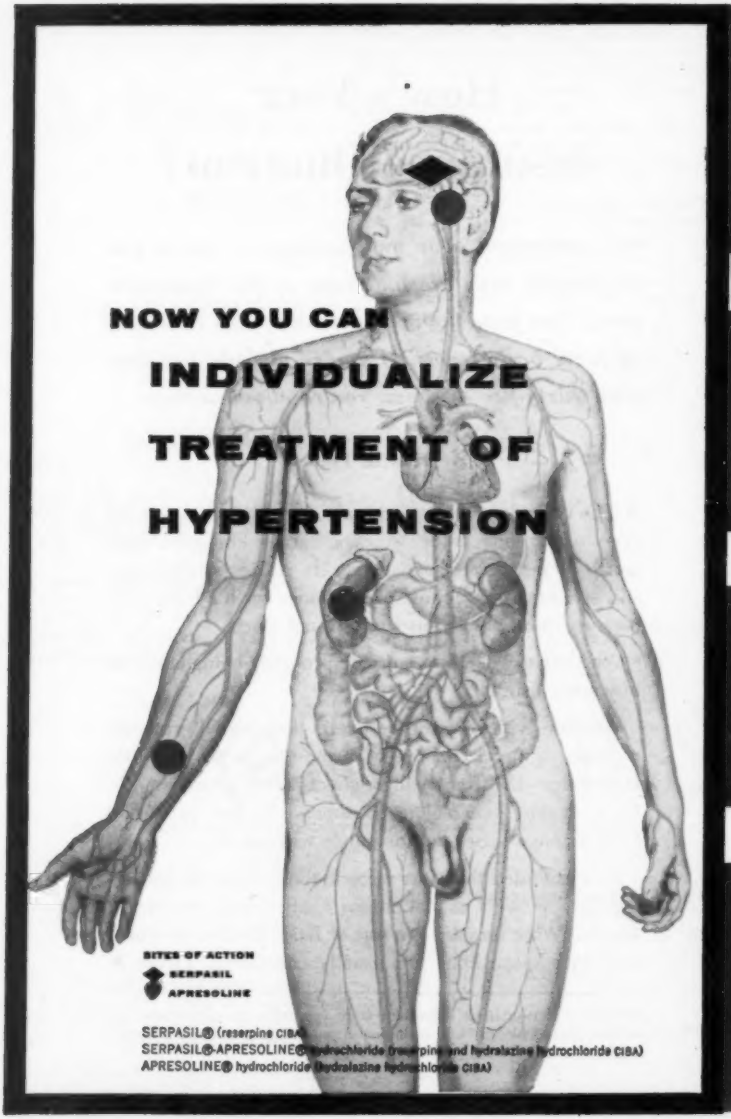
● The typical private practitioner, according to MEDICAL ECONOMICS' most recent studies, carries about $45,000 worth of insurance on his life. He carries smaller—but still substantial—amounts of insurance on his home, his personal possessions, his professional assets.

And at this very moment, he's probably being asked to buy *more* insurance.

Are you typical in this respect? If so, you'll probably welcome a quick review of insurance terms. A little knowledge—far from being dangerous—is your best defense against overzealous salesmen. In any case, you can't manage your own insurance without it.

I've excluded the most esoteric terms from the following list, as well as definitions that almost everybody knows. What remains is a sort of Basic English in which insurance discussions are usually conducted. [MORE ▶

THE COMPILER *of these definitions is an insurance consultant who has written such books as "Life Insurance From the Buyer's Point of View" and "How to Start a Life Insurance Program."*


NOW YOU CAN
INDIVIDUALIZE
TREATMENT OF
HYPERTENSION
SITES OF ACTION
SERPASIL
APRESOLINE
SERPASIL® (reserpine CIBA)
APRESOLINE® hydrochloride (hydralazine hydrochloride CIBA)

If you can check thirty-five of these terms as already familiar, you're well prepared for the next agent who calls.

☐ ACCIDENTAL DEATH BENEFIT. The "double indemnity" payment provided in many life insurance policies. Twice the face value of the policy is paid if the insured person dies as the result of an accident.

☐ ALL-RISK INSURANCE. A broad policy that insures property like furs and jewelry against damage from all causes, except certain hazards specified in the policy.

☐ AGE. For life insurance purposes, the age of the policyholder on his nearest birthday.

☐ AUTOMATIC PREMIUM LOAN. A loan made automatically by the insurance company to pay a premium that the policyholder has failed to pay within thirty-one days of its due date. This provision is frequently added without extra charge to life insurance policies.

☐ BINDER. A temporary agreement requiring the insurance company to pay the agreed-upon benefits if a loss occurs while the application is being considered.

☐ BLANKET INSURANCE. A single policy that covers several different properties.

☐ BROKER. An insurance salesman who acts as the agent of the policyholder, rather than as the agent of insurance companies.

☐ CANCELABLE POLICIES. Insurance contracts that may, after proper notice, be terminated by either the company or the policyholder. Most forms of insurance fall into this category, the main exceptions being life and marine insurance.

☐ CASH SURRENDER VALUE. The sum that a policyholder can get by turning in his policy, as shown in a table thereon.

☐ CO-INSURANCE CLAUSE. A provision requiring the policyholder to keep the face value of his policy at or above a specified percentage (usually 80 per cent) of the insured property's total value, if he wants to collect in full for any losses.

☐ DEFERRED ANNUITY. An annuity that pays a life income starting at the end of some specified period.

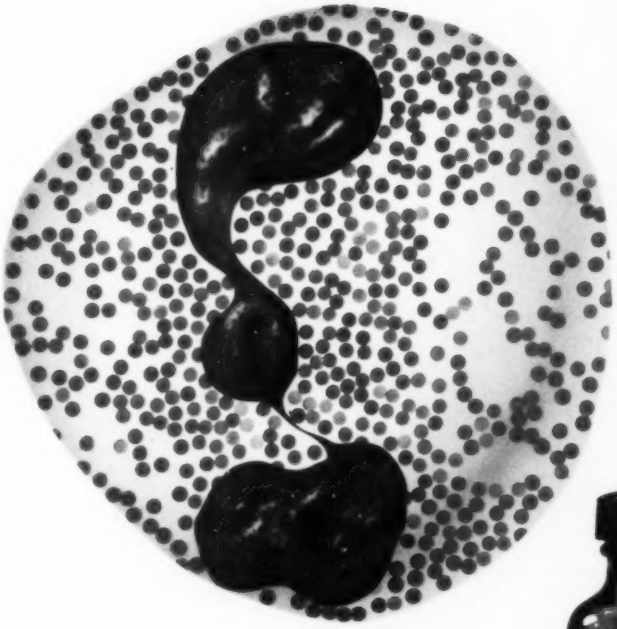
☐ DIVIDEND. That part of an insurance premium that isn't needed to pay claims or to meet operating costs, and hence is returned to the policyholder.

☐ ENDOWMENT POLICY. An insurance policy stipulating that the face amount will be paid to the policyholder at the end of a specified period, or to his beneficiaries if he dies before then.

☐ ENDORSEMENT. An additional provision, or "rider," that calls for changes in the basic insurance policy.

☐ EXTENDED TERM INSURANCE. New coverage equivalent to the face value of a life insurance policy that is being discontinued, such coverage to be kept in force for as long a period as the old policy's cash surrender value will pay for.

☐ EXTENDED COVERAGE. Broader protection added by endorsement to



a first choice
for all types
of hypersensitivity

TABLETS..... 4 mg.
REPETABS®.... 8 mg.
INJECTION....10 and 100 mg./cc.

CHLOR-TRIMETON® Maleate, brand of chlorprophenpyridamine maleate.

relief of hay fever
is prompt
and sustained
with unexcelled freedom
from side effects

in resistant hay fever

and other allergies

new

convenient higher strength

12 mg.

CHLOR-TRIMETON REPETABS

Just one, 12 mg. CHLOR-TRIMETON REPETAB provides both immediate and sustained relief throughout the day or night.*

CHLOR-TRIMETON—the unsurpassed antihistamine—available in a variety of convenient dosage forms.

CHLOR-TRIMETON REPETABS 12 mg., for rapid, uninterrupted comfort in resistant allergies. Bottles of 100 and 1000.

CHLOR-TRIMETON REPETABS 8 mg., for 8 to 12 hours' sustained relief. Bottles of 100 and 1000.

CHLOR-TRIMETON Tablets, 4 mg., (scored), for initiating and adjusting therapy. Bottles of 100 and 1000.

*CHLOR-TRIMETON® maleate, brand of chlorpheniramine maleate
REPETABS, Repeat Action Tablets.

SCHERING CORPORATION • BLOOMFIELD, N. J.

When your geriatric, dyspeptic, underweight, or gallbladder patient doesn't respond to diet, the cause is frequently an inability to *utilize food.*

CONVERTIN furnishes the dietary catalysts necessary for efficient absorption in these individuals.

The specially layered construction of CONVERTIN provides selective release of ingredients to assure efficient absorption in the stomach and small intestine.

Each CONVERTIN Tablet provides:
a sugar-coated outer layer of:
Betaine Hydrochloride.....130.0 mg.
(Provides 5 minims Diluted Hydrochloric Acid U.S.P.)
Oleoresin Ginger.....1/600 gr.
Surrounding an enteric-coated core of:
Pancreatin.....62.5 mg.
(Equiv. 250 mg. U.S.P.)
Desoxycholic Acid.....50.0 mg.
DOSAGE: One or two tablets with or just after meals.
SUPPLIED: In bottles of 84 and 500 tablets.

B. F. ASCHER & COMPANY, INC.
Ethical Medicinals
KANSAS CITY, MISSOURI

the basic policy. The coverage of a fire insurance policy, for example, may be extended so that the property will also be insured against losses caused by windstorm, hail, explosion, riot, etc.

☐ FLOATER POLICY. An insurance policy that covers movable property regardless of location at the time of the loss. Jewelry, furs, and surgical instruments are often protected by floaters.

☐ INCONTESTABLE CLAUSE. A provision in all life insurance policies, stipulating that the company can't dispute payment of claims (except for nonpayment of premiums) after the policy has been in force for a specified period—usually one or two years.

☐ INSPECTION. A check-up of the prospective policyholder's health, reputation, financial status, etc., aimed at securing more information than that obtained via application blank and medical examination. The company always "inspects" people who apply for sizable amounts of life insurance.

☐ INSURABLE INTEREST. A person's interest in life or property that may result in financial loss. Only if this

"Time for your therapy."

"insurable interest" exists can he buy insurance coverage on the life or property in question.

☐ JOINT LIFE AND SURVIVORSHIP ANNUITY. A contract under which the insurance company pays an income until the last of the named annuitants dies.

☐ LEVEL-PREMIUM INSURANCE. Life insurance under which the premiums stay the same throughout the life of the policy, though the amount of insurance may be reduced periodically.

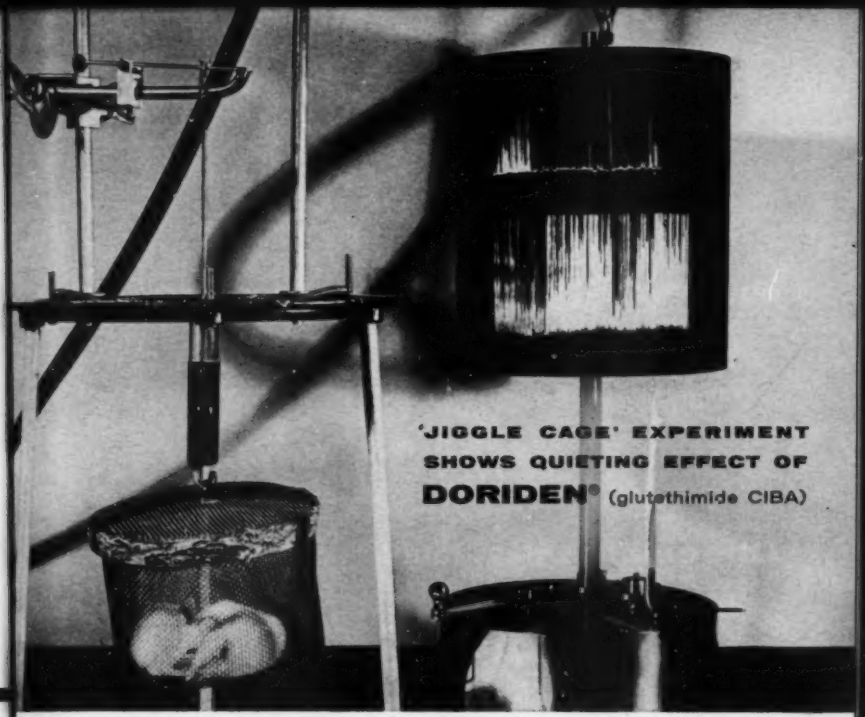
☐ MARINE INSURANCE. Originally, a policy that covered the risks of ocean transportation. The term is now applied to all types of insurance that provide against loss in transit.

☐ MEDICAL PAYMENTS INSURANCE. A feature often added to liability policies. It pays medical, surgical, hospital, ambulance, nursing, and funeral expenses—up to a specified limit—for people accidentally injured, whether or not the insured person is at fault.

☐ MORTGAGEE CLAUSE. A provision stipulating that insurance proceeds to the extent of his interest be paid to the holder of the mortgage on the insured property.

☐ NET AMOUNT AT RISK. The face amount of a life insurance policy minus its current cash value.

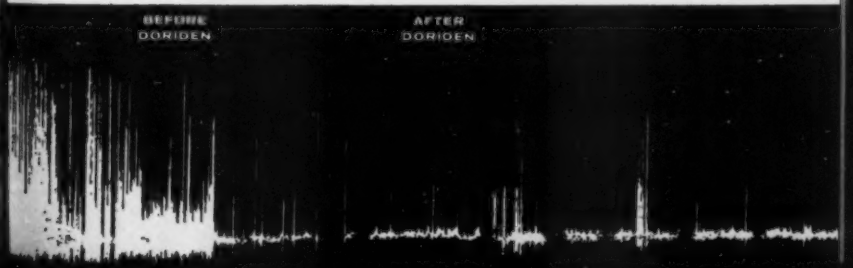
☐ NON-MEDICAL INSURANCE. Life insurance issued without requiring a medical examination. [MORE ▶



That **DORIDEN**—a totally new nonbarbiturate hypnotic and sedative—is effective as a quieting agent is demonstrated by this pneumatic movement recorder (jiggle cage), which measures the activity of laboratory animals. Note the marked change in the activity of mice after the administration of DORIDEN. Further evidence of the sedative and hypnotic effectiveness of DORIDEN is provided by numerous clinical studies. DORIDEN acts in 15 to 30 minutes and affords 4 to 8 hours of sound refreshing sleep. Present clinical evidence indicates it is not habit forming.

Tablets (white, scored), 0.25 and 0.5 Gm. C I B A SUMMIT, N. J.

2/2136N



doubles the power to resist food in obesity

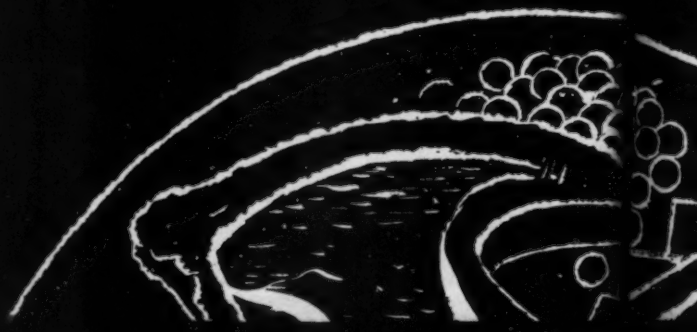
Obocell has this double action:

1. Controls your patients' appetites at meals.
2. Appeases their gnawing bulk hunger.

More than that, the effect of Obocell "carries over" between meals so that your patients are not tempted to break their diets.

. . . And Obocell saves money for your patients.

IRWIN, NEISLER & COMPANY • DECATUR, ILLINOIS • TORONTO 1, ONTARIO



Obocell®

Each Obocell tablet contains:

d-Amphetamine Phosphate (dibasic) 5 mg.
Nicel* 160 mg.

*Irwin-Neisler's brand of High Viscosity Methylcellulose.

Bottles of 100, 500 and 1000.

XUM

☐ ORDINARY LIFE POLICY. Life insurance under which the premiums must usually be paid as long as the insured person lives.

☐ PERSONAL PROPERTY FLOATER. A policy that protects personal property against nearly all risks, regardless of location at the time of the loss. A specified deduction (often $25) is sometimes subtracted from any settlement.

☐ PREFERRED-RISK POLICY. Life insurance available at lower-than-average premiums to applicants who are better-than-average risks.

☐ RATING-UP. A method by which insurance companies deal with substandard life insurance risks. Applicants in this category are charged an extra premium, or issued a policy computed for an age higher than their actual age.

☐ RENEWABLE POLICY. A policy that the holder has a guaranteed right to renew at the end of its term, simply by payment of a stipulated premium. Most life insurance policies and noncancelable health and accident policies are guaranteed renewable to a stipulated age.

☐ RENTAL-VALUE INSURANCE. A type of fire insurance that protects the holder against rental expense while the insured property is being rebuilt after a casualty loss.

☐ SHORT-RATE PREMIUM. The premium rate that applies when a policyholder cancels his insurance pol-

icy before the end of its term. It's computed at a higher rate than normal, to cover the company's expense in writing the policy.

☐ SUBROGATION. A policy provision giving the insurance company the right to recover, from the person responsible for the loss, the amount it pays out under the policy.

☐ SURVIVORSHIP ANNUITY. An annuity that provides an income for another person after the death of the policyholder. Sometimes a lapse of several years is stipulated before the survivor can begin to receive income payments.

☐ TERM INSURANCE. A life insurance policy written for a limited period (but often renewable) and generally having no cash value at the end of its term.

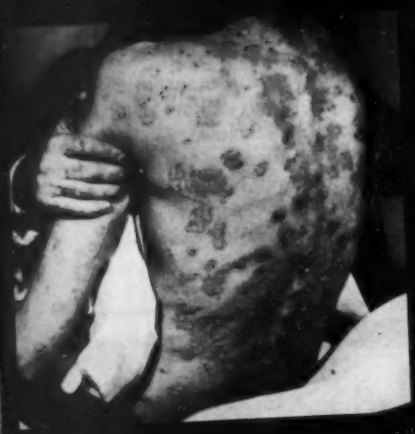
☐ TWISTING. The efforts of a life insurance agent to induce a policyholder to drop one company's policy in favor of another's, merely to provide a commission for the agent.

☐ VALUED POLICY. A policy that states the exact amount to be paid in the event of total loss.

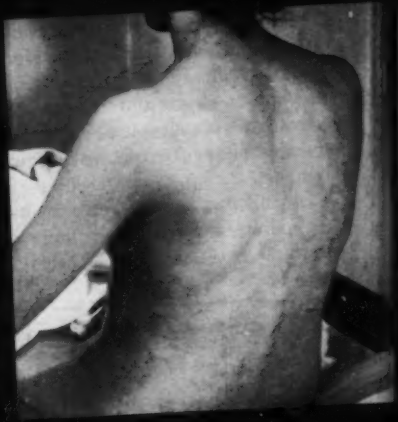
☐ WAIVER OF PREMIUM. A provision added to life insurance and noncancelable health and accident policies for an extra charge. It states that further premium payments will not be required if, after a specified period, the policyholder becomes totally and permanently disabled.

END

Psoriasis
of 5 years duration



Skin Cleared
after only 7 weeks



Belmont Laboratories, Philadelphia, Pa.

MAZON

dual therapy

Chronic psoriasis is stubborn and hard to clear up, leading to great patient discomfort. These clinical photographs illustrate the effectiveness of MAZON dual therapy in an actual case of five years' duration —and the skin was clear in a period of only seven weeks. MAZON dual therapy can be of great value to you in your treatment of not only acute and chronic psoriasis, but also exzema, alopecia, ringworm and other skin conditions not caused by or associated with systemic or metabolic disturbances.

MAZON Soap cleanses the affected area and prepares it for the action of MAZON Ointment.

MAZON is greaseless and requires no bandaging. Apply just enough to be rubbed in, leaving none on the skin.

Dispensed only in the original blue jar.

How to Get Started As an Investor

[CONTINUED FROM 160]

He picked up his phone and asked a clerk in the back office to quote Monsanto. Holding the telephone, he explained that the clerk was relaying the request by private wire to the New York office. There another clerk would call the quotation department of the Stock Exchange, which was in constant phone touch with quotation clerks at all the trading posts.

"They're big, horseshoe-shaped desks down on the trading floor. Hundreds of brokers, including a couple of P & C partners, are milling around these eighteen big desks. To each desk, or 'post,' are assigned from twenty-five to a hundred stocks. For each stock there's what they call a specialist, a broker who keeps the order book on that stock. All limit and stop orders, either to buy or sell, are recorded in his book."

Humphrey teetered in his swivel chair, still holding the phone. "Now the quotation clerks, inside the horseshoe, keep getting the latest quotes from these specialists, standing just outside. The clerks pass them on to the quotation depart . . ."

He stopped suddenly, listening to the phone. Then he hung up and

NOW *happy travelers chew*

Bonamine* HCl

Brand of meclizine hydrochloride

chewing tablets

Probably 30 to 50% of all travelers experience some degree of pleasure-spoiling malaise, anorexia, nausea and vertigo. For these motion-sensitive vacationers, you can prescribe new BONAMINE CHEWING TABLETS to insure happier travel, no matter what the method of transportation.

For the convalescent or the invalid traveling for his health, BONAMINE helps to avoid the strain imposed by vertigo, nausea and vomiting. Also indicated for control of nausea, vomiting and vertigo associated with labyrinthine and vestibular disturbances, Menière's syndrome and radiation therapy.

BONAMINE rarely causes drowsiness or other unwanted reactions.

SUPPLIED on prescription only:

Chewing Tablets (New)—25 mg., candy-coated, mint-flavored. Packages of 8.

Tablets—25 mg., scored and tasteless. Boxes of 8 and bottles of 100 and 500.

*TRADEMARK

Pfizer **PFIZER LABORATORIES,** Brooklyn 6, N. Y.
Division, Chas. Pfizer & Co., Inc.

scribbled on a slip of paper: "95¼-⅜." He showed it to the doctor.

"That means that the highest order to buy on the specialist's book is 95¼, and the lowest order to sell is 95⅜. In other words, 95¼ is the most that anyone is willing to pay for Monsanto at the moment, and 95⅜ is the lowest that anyone's willing to sell it for. A market order right now will probably be executed between those two figures."

"How?" said Dr. Shafer.

Buyer Meets Seller

"Well, the buying broker gets the order from his office. He has a phone booth over at the side of the floor; there's a big annunciator board on the wall that flashes his number whenever his office wants him on the phone. He jots down the order and legs it over to the Monsanto post. He finds the specialist, gets the bid and ask, then offers an eighth more than the best bid. Meanwhile a new limit sell order may come onto the books at 95⅜, from another broker.

"Then it may turn out that some taxidermist in Squeedunk a few minutes before has decided to sell his Monsanto at the market and build a new taxidermy shop. Up gallops his broker; he squints at the book and says, 'Sell a hundred at a half.' The first broker says, 'Sold,' and that finishes it. A clerk in the horseshoe writes "100 MTC 95½" on a slip and sends it by pneumatic tube to the ticker teletypists, and they print it on the tape." [MORE ▶

NEWS

for every Doctor who smokes
for every patient who seeks smoking advice

NEW WATER-ACTIVATED FILTER REMOVES UP TO 92% OF NICOTINE, 76% OF TARS FROM ANY CIGARETTE, PLAIN OR FILTER-TIP*

Uses Oriental "Hookah" Technique to Cleanse, Cool Smoke, Leaving Full Tobacco Taste and Flavor

Aquafilter, the unique water-activated filter, offers a new, practical approach to the problem of how to limit and control nicotine and tar intake without reducing the pleasure of smoking.

HOW *Aquafilter* WASHES OUT NICOTINE AND TARS

The AQUAFILTER, a replaceable cartridge of absorbent material, holds about one milliliter of water—enough to trap three to four times its weight in nicotine. Acting as a miniature condenser, the AQUAFILTER chills gaseous nicotine to the liquid phase. At the same time it strips the smoke of tars.

The mainstream of smoke from the average king size cigarette, in tests conducted under standards established by the U. S. Government, shows only 8% of nicotine and 24% of tars passing through the AQUAFILTER. Temperature of smoke is lowered three to four times more effectively than by any other smoking method tested.*

*Independent testing laboratory reports available on request.

The AQUAFILTER will soon be available throughout the United States and Canada

Aquafilter CORPORATION • *270 Park Avenue • New York, 17, N. Y.*

"What if there's no taxidermist?"

"Then the buyer pays five-eighths, the lowest limit sell order on the book."

"Okay," the doctor nodded. "Go ahead and put me in for twenty-five shares at the market."

"One thing more. Whatever the price of the next deal, you'll pay a quarter of a point more."

"How come?" Shafer asked.

"You're buying an odd lot—less than a hundred shares. All those trades you see on the tape are in round lots—a hundred shares or multiples of a hundred. All orders for ninety-nine shares or less have to go through an odd-lot broker."

"And how's that work?"

"Two big odd-lot brokerage houses in New York," Humphrey told him, "handle most of the Stock Exchange odd-lot business. They're brokers' brokers, dealing only with firms like ours. One of our floor partners, on receipt of your order, will take it to an odd-lot broker who'll sell you your twenty-five Monsanto at a quarter of a point—that's 25 cents—over the price of the next round lot printed on the tape. Offsetting your order he may have a twenty-five share market sell order from another firm, which he'll fill at a quarter of a point *under* the round-lot price.

"If the stock you selected had been selling below $40 a share, the odd-

lot differential would have been only an eighth of a point. He makes an eighth- or a quarter-of-a-point profit on each deal—and that's his bread and butter."

"Suppose he doesn't have an offsetting order?"

"He'll fill yours anyhow from a few hundred shares of Monsanto he carries as inventory."

The doctor noticed that the quotation board had clicked up another Monsanto sale, this time at 95¼. "Say, let's get that order in," he said. "She's moving up."

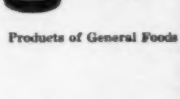
"Don't fret over the fractions," the customers' man advised him. "You're an investor, remember? You're going to hold this stock quite a while—years maybe. Think in terms of the long pull. Leave the fractions to the shiny-pants boys up there in the leather chairs."

He wrote the order on a slip, dispatched it via an office boy to the wire clerk, then told the doctor, "We'll have a confirmation in a few minutes, if you care to wait. As soon as our floor partner has executed it, he'll report the price back to our main office and they'll let us know."

Five minutes later the tape again flashed "MTC 95¼." Humphrey said, "So now you probably have yours, at three-quarters." Shortly the boy brought a report slip bearing the doctor's name and account num-

Do you sometimes feel that a patient would benefit from drinking less coffee, because he is "caffein sensitive"? Why not tell him he can drink all the coffee he wants, as long as it is Sanka Coffee —97% caffein-free?

New, Extra-Rich Sanka is a wonderful coffee, Doctor. You'll enjoy it yourself.



Products of General Foods

SANKA COFFEE

DELICIOUS IN EITHER INSTANT OR REGULAR FORM

ber and a pasted-on strip of teletype tape reading, "B 25 MTC @ 95¼."

"Incidentally," Humphrey smiled, "you'll be getting your first dividend check next month, for about $15. The stock sells ex-dividend tomorrow. Don't let it bother you if it slips off about a half point because of that. That's roughly the amount of the dividend—about 60 cents a share."

"What does ex-dividend mean?" said Shafer.

"Last month Monsanto's board of directors declared a regular quarterly dividend to stockholders of record on the company's books as of the sixteenth of this month. That's three days from today. The settlement period on Stock Exchange transactions is also three days; you have that long to pay for your stock and the seller has that long to deliver his stock certificate to us for transfer. This is the thirteenth, so we'll get the stock on the sixteenth and your name will go on the company's books the same day. However, anyone buying the stock tomorrow won't have it transferred to his name until the seventeenth, too late to get the dividend; instead it will go to the previous owner. That's why we say the stock sells ex-dividend tomorrow."

It Takes Time

"Why do I have to wait till next month to get the dividend?"

"It takes the company several weeks after the record date to draw up the checks and mail them out."

As the two men talked, a muted gong sounded somewhere in the office. Looking up, Dr. Shafer saw that the wall clock said 3:30. Humphrey explained that the market had just shut up shop for the day. "They trade from 10 till 3:30 then take the rest of the day and sometimes half the night to settle their accounts." The ticker tape was still tooling along, but a few moments later flashed "MARKET CLOSED," then went on to report the day's high and low prices for each stock, bid and ask prices of stocks not traded that day, and other market information.

Seasoned Investor

Dr. Shafer bade Humphrey goodbye. The next day's mail brought him formal confirmation of the transaction from Putz & Cawles. The slip gave all the details of the deal, including the total sum he owed the brokers. That evening he picked up a Chicago paper and noted with satisfaction that the stock had again closed at 95¼, despite the "xd" symbol beside it. In effect, he figured, it had gained half a point.

The doctor's stock certificate arrived two weeks later. What with its engraved scrollwork and official phraseology proclaiming Herbert V. Shafer the owner of record of twenty-five common shares of the Monsanto Chemical Corporation, the document was indeed a thing of beauty.

That day he phoned Humphrey to ask, like a veteran, "How're they quoting General Dynamics?" END

'Blue Shield Didn't Pay Me Enough'

[CONTINUED FROM 145]

pressed fracture of the lateral plateau of the left tibia. Her physician attended her in the hospital for four days before the operation and for ten days afterward. Later, he removed the cast and made three or four house calls.

The doctor's fee considerably exceeded Blue Shield's allowance of $150. Although the woman's husband promptly paid the balance, the doctor had the case brought before the committee anyway. As a result, the health plan's allowance was boosted by $50.

¶ A Brooklyn medical man protested the health plan's $125 allowance for a biopsy and resection of a tumor from the popliteal fossa. (The wound had broken down after the operation, and a total of twenty-eight visits for cauterizations and dressings had been necessary.) The verdict: Let the plan's $125 stand.

¶ For a multiple-procedure operation (subtotal gastrectomy, release of colon torsion, appendectomy), a Manhattan surgeon had billed his patient for a good deal more than the $200 that was the plan's scheduled allowance for subtotal gastrec-

MAY WE SUGGEST:

When DIARRHEA proves

recalcitrant to treatment, try

DONNAGEL®

Robins

(Donnatal with Kaolin and Pectin Compound)

r all ages... in all seasons...

Donnagel is building an extraordinary record of clinical success, even in stubborn cases, whether organic, functional or "emotional".

Its unique formula comprehensively embraces the gastrointestinal adsorbents and detoxicants kaolin and pectin, with the proven spasmolytic-sedative properties of 'Donnatal', and the superior antacid action of dihydroxy aluminum aminoacetate... in a highly palatable suspension.

Each 30 cc. of Donnagel contains:

Hyoscyamine Sulfate	0.1037	mg.
Atropine Sulfate	0.0194	mg.
Hyoscyamine Hydrobromide	0.0065	mg.
Phenobarbital (¼ gr.)	16.2	mg.
Kaolin (90 gr.)	6.0	Gm.
Pectin (2 gr.)	130.0	mg.
Dihydroxy aluminum aminoacetate (7½ gr.)	0.5	Gm.

A. H. ROBINS CO., INC. · RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

tomy. (U.M.S., like most Blue Shield plans, pays for only the most expensive procedure when two or more operations are done at the same time within the same operative field.) The committee voted not to increase the plan's allowance, in this case.

Change the Schedule

In addition to considering individual cases like the above, the committee sometimes makes recommendations for changes in the U.M.S. fee schedule. Before such changes can become official, they must be approved by the health plan's Medical Policy Committee. But the policy committee usually goes along with the review board's recommendation.

In its first four years, the doctors' committee suggested thirty-one increases in scheduled items. Of the twenty-two recommendations acted on by the Medical Policy Committee so far, only three have been flatly rejected. Nineteen changes have been approved, either in full or in part. Some examples of the increases approved in full:

Fees Increased

Thyroidectomy, total or complete —raised from $150 to $175.

Excision of Baker's cyst (synovial cyst of popliteal space)—raised from $25 to $100.

[MORE▶

buffered "aluminum" antacid
(but very low in aluminum content)'
in tasty *liquid* form

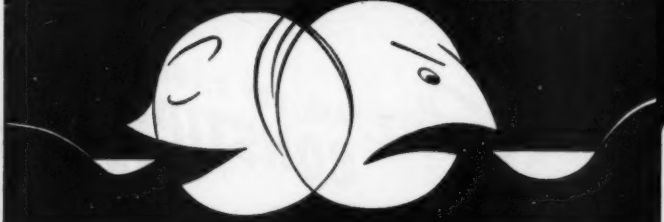
ALZINOX *Magma*

[Dihydroxy Aluminum Aminoacetate Patch]

provides rapid and prolonged effect without excessive neutralization... rapid dispersion permits protective coating action... pleasant tasting without grittiness or astringency... **and**

ALZINOX PATCH

your patient takes ALZINOX Magma
by the teaspoonful – **not** tablespoonful



For flexibility of dosage:

***ALZINOX** Magma*
0.5 Gm. (7.7 grs.) per 5 cc., bottles of 8 fl. oz.

***ALZINOX** Tablets*
0.5 Gm. (7.7 grs.), bottles of 100 and 500.

1. Council on Pharmacy and Chemistry, A. M. A.: New and Nonofficial Remedies 1952, Philadelphia, J. B. Lippincott Company, 1952, p. 311.

For added sedation and spasmolysis:

Magma ALZINOX with Phenobarbital (¼ gr. per 5 cc.) and Homatropine Methyl Bromide (1/100 gr. per 5 cc.), bottles of 8 fl. oz.

Tablets ALZINOX with Phenobarbital (¼ gr.) and Homatropine Methyl Bromide (1/100 gr.), bottles of 100 and 500.

THE E. L. PATCH CO.
STONEHAM, MASSACHUSETTS

Laryngofissure with removal of tumor—raised from $100 to $150.

From time to time, the committee also recommends changes in medical policy.

And these, too, are usually followed—as with the recent suggestion that allowances for compound fractures be increased by 50 per cent over allowances for closed reductions.

They're Doctors First

There's no denying that, in all such matters, the Physicians' Review Committee eases the administrative burdens of the Blue Shield plan. But the main value of the committee, according to U.M.S. officials, lies in the fact that it's composed of private practitioners. It's certainly true that the doctor with a grievance prefers to have his complaint handled by men who understand his side of the story.

And yet, as you've gathered by now, the doctor-members of the review committee haven't tended to be overgenerous with subscribers' money. As Dr. Raider puts it:

"The committee members have demonstrated that physicians *do* accept responsibility in the successful operation of Blue Shield. They have allayed the fears of those who once felt that participating doctors could not consider fee questions impartially." END

THORAZINE*

now the therapy of choice in

ALCOHOLISM

Mitchell[1] observed that 'Thorazine' therapy offered these definite advantages over the usual barbiturate and mephenesin treatment of alcoholism:

ALL PATIENTS QUIETED

They "soon became quiet and dropped into light sleep yet could be easily awakened to receive medication or nourishment."

NURSING CARE SIMPLIFIED

"The patients were more amenable to suggestions from the nursing and medical staff, there were fewer falls from bed."

FOOD RETAINED EARLIER

Nausea and vomiting were stopped, and the patients "were able to retain solid food 18 to 24 hours earlier than the barbital treated group."

SHORTER HOSPITAL STAY

Patients "were in condition to be discharged from the hospital on an average of 24 hours earlier" than those treated with barbiturates.

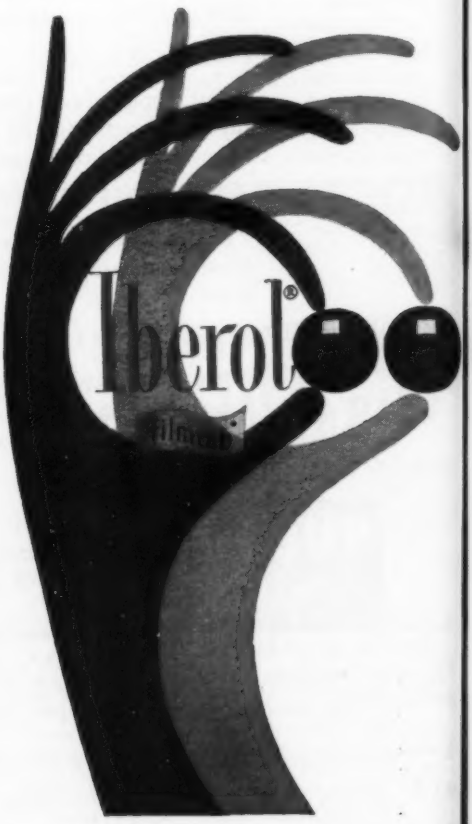
1. Mitchell, E. H.: Chlorpromazine in the Treatment of Acute Alcoholism, Am. J. M. Sc. *229*:363 (April) 1955.

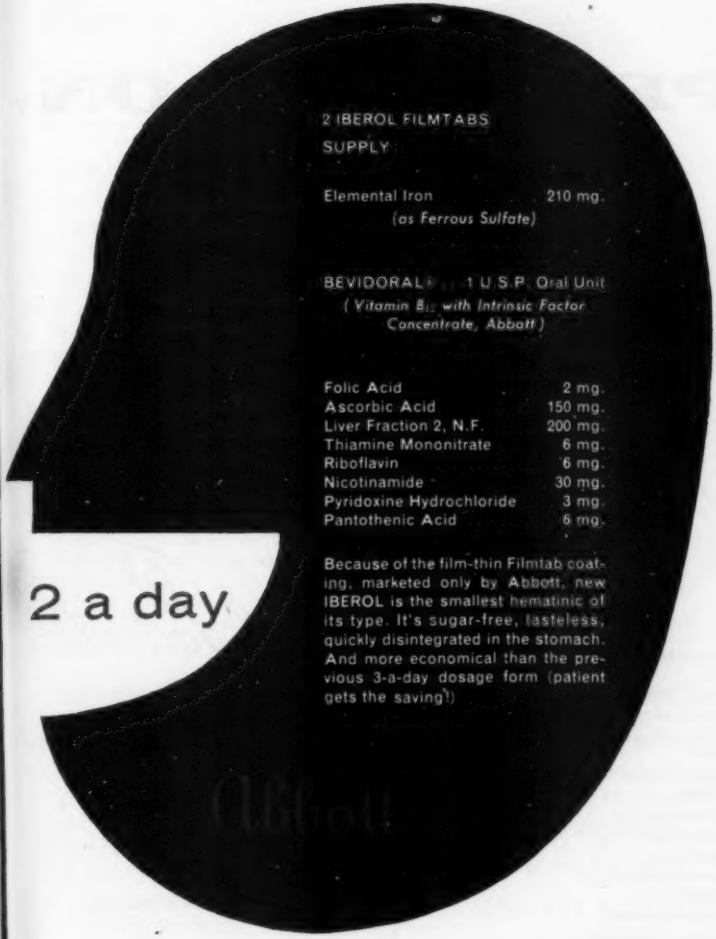
'Thorazine' Hydrochloride is available in 10 mg., 25 mg., 50 mg. and 100 mg. tablets; 25 mg. (1 cc.) and 50 mg. (2 cc.) ampuls; and syrup (10 mg./5 cc.).

For information write: *Smith, Kline & French Laboratories*
1530 Spring Garden Street, Philadelphia 1

*T.M. Reg. U.S. Pat. Off. for S.K.F.'s brand of chlorpromazine.

COMPLETE IRON-PLUS THERAPY FOR THE ANEMIAS




2 IBEROL FILMTABS
SUPPLY
Elemental Iron 210 mg.
(as Ferrous Sulfate)
BEVIDORAL 1 U.S.P. Oral Unit
(Vitamin B12 with Intrinsic Factor Concentrate, Abbott)
Folic Acid 2 mg.
Ascorbic Acid 150 mg.
Liver Fraction 2, N.F. 200 mg.
Thiamine Mononitrate 6 mg.
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Because of the film-thin Filmtab coating, marketed only by Abbott, new IBEROL is the smallest hematinic of its type. It's sugar-free, tasteless, quickly disintegrated in the stomach. And more economical than the previous 3-a-day dosage form (patient gets the saving!)
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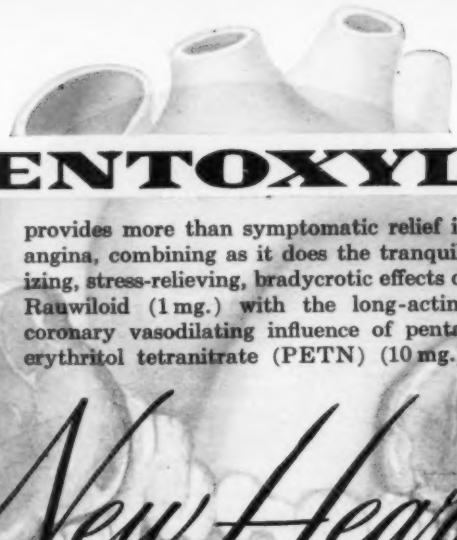

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provides more than symptomatic relief in angina, combining as it does the tranquilizing, stress-relieving, bradycrotic effects of Rauwiloid (1 mg.) with the long-acting coronary vasodilating influence of pentaerythritol tetranitrate (PETN) (10 mg.).

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In both hypertensive and normotensive patients with angina or status anginosus, PENTOXYLON is equally indicated, since Rauwiloid lowers elevated blood pressures, but does not affect normal tension.

Dosage: One to two tablets q.i.d.

Riker LABORATORIES, INC., LOS ANGELES, CALIF.

Report on Unethical Practices

[CONTINUED FROM 124]

ment that a man should devote his entire time to his specialty in order to master its complexities and keep abreast . . . this has been rather convincingly answered by those who point out that the idle young surgeon is not necessarily spending his nonproductive time in studying. He is more likely to be doing his own bookkeeping or building his wife a kitchen cupboard because he can't afford to hire [anyone to get] these chores done. As one young surgical specialist said frankly:

The first year in practice I lost $1,800, and the next year I broke even . . . I spent those two years with potography as a hobby, to kill time between patients.

WE THEREFORE RECOMMEND:

1. That a subcommittee of the Medical Practices Committee be created to begin work on a relative value scale for the whole of the practice of medicine and surgery. Such a subcommittee could begin with the relative value scale produced by the thoracic surgeons (the only group which, as far as we can determine, has produced such a scale) and develop and broaden this approach, calling in as consultants representatives of general practice and all the specialties, as well as using

the services of such non-medical advisors as were needed.

The scale which they would produce would be in points, not in dollars. It would be an indication for both doctors and the public of the proper relation between fees for various medical and surgical services. Its existence would be of interest to underwriters of health insurance and to all organizations, both medical and non-medical, which are concerned with fee schedules. As it proved its usefulness and as more and more people became aware of it, the economic inequities which foster fee splitting would probably decrease.

We are aware in making this recommendation that we *may* be suggesting either a rise in the over-all cost of medical care or a net reduction in that portion of the surgeon's fee which covers his actual operating time. But the scale will not be a fee schedule, and the dollar value assigned to the points will determine whether the scale raises the total cost of medical care or [whether it] changes the fees to provide more appropriate recompense for medical work.

WE FURTHER RECOMMEND:

2. That a program of public education on the value of diagnostic and medical work be fostered by the A.M.A. Public Relations Depart-

ment to increase public appreciation of non-surgical work.

WE ALSO RECOMMEND:

3. That the A.M.A. communicate to the specialty boards the findings of this survey, encouraging the boards to reappraise the value of their regulations restrictive on the practice of those seeking or holding board certificates . . .

4. And that the A.M.A. continue to use its full influence to discourage the arbitrary restrictions by hospitals against general practitioners as a group, regardless of their qualifications as individuals.

We can see little hope of curing fee splitting by superimposing more oaths, rules, restrictions, regulations, and inspections. The Columbus Plan has the advantage of providing the doctor who *wants* to stop fee splitting with the psychological support of a like-minded group . . . A system by which the name of the operating surgeon was made part of the data on the patient's hospital bill would probably eliminate ghost surgery in cooperating hospitals.

But there is a long human history of broken oaths and regulations where law does not conform to the realities of a situation.

The existence of a relative value scale, the encouragement of higher fees for diagnostic and medical work, and the removal of enforced

limitations on practice would undoubtedly result in changes of the patterns of practice. Many doctors, pleased with their practices as they are, may prefer not to see changes.

However, we have ascertained to our complete satisfaction that the financial inequities and the attempts to departmentalize medicine within rigid, artificial boundaries are basic causes of unethical practice.

It seems clear that there is a choice between the kind of underhanded subsidy of diagnostic and medical work through fee splitting, and an open re-evaluation of fees.

There is a choice between a divided profession with arbitrary, unrealistic rules which many doctors surreptitiously evade, and a profession in which each man is free to find his own place without resorting to subterfuge.

Section 2

Unethical Practices and Public Hostility Toward the Profession

As the Committee worked on its assignment, it became evident that the unethical practices we were told to investigate and the unfavorable publicity about these practices do not exist in a vacuum.

Public attitude toward the profession is the measure which editors use in deciding to buy and use these derogatory articles. Beyond that, doctors in their daily practice are influenced by the public's emotional reaction to the profession and by the public's demands and disappointments.

Therefore, public attitudes are both cause and result, too thoroughly intermingled with the entire problem to be disentangled from it. Thus we found ourselves in the midst of a study of the total public relations problem of medicine.

Some of the causes for the public's disaffection with medicine are so well known that we will not report them in detail . . . Organized medicine on various levels, with various approaches, is trying to find solutions for these problems. This committee can only emphasize the urgency which attaches to the solutions . . .

Beyond these well-known aspects, there seem to be some other fundamental public relations problems which our work has revealed—problems which tie in closely to unethical practices and adverse publicity. The two which seem clearest to us are treated below. [MORE▶

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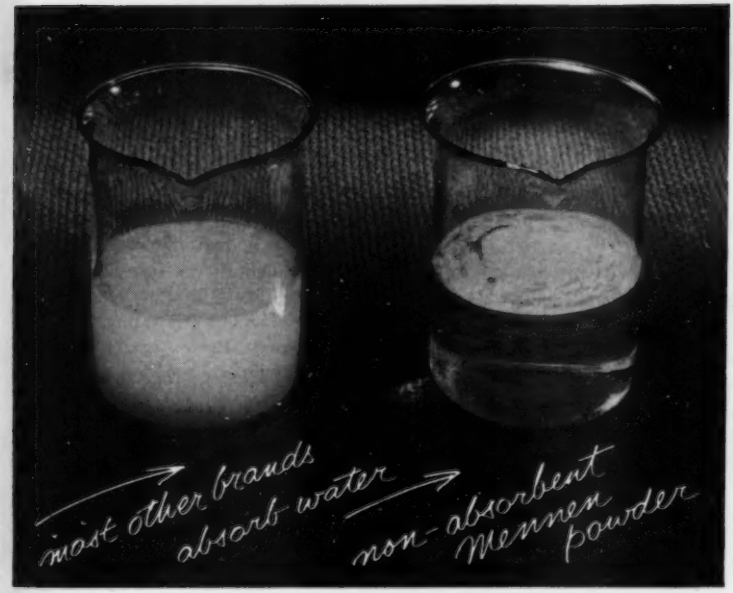
Note the striking difference in water-absorption between Mennen Baby Powder and the other brand! Mennen . . . the wet-resistant powder, creates a barrier between diaper moisture and baby's skin. And it *clings* far longer than almost every other brand . . . thus gives better anti-rash protection. The improved formula, which includes the finest Italian talc, results in the superior qualities of Mennen Baby Powder.

MENNEN . . . BABY SPECIALIST SINCE 1880



invitation to asthma?

not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes . . . Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours . . . Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

Tedral provides:

Theophylline	2 gr.
Ephedrine HCl	3/8 gr.
Phenobarbital	1/8 gr.

in boxes of 24, 120 and 1000 tablets

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WARNER-CHILCOTT

A. *The public needs to know to what degree medicine is an exact science and whether doctors are supposed to be infallible.*

. . . Obviously, medicine as magic in the primitive society was not permitted to be less than a sure thing. If it failed to accomplish its objective, then someone had neglected to perform the ritual correctly. And if the medicine was actually a function of the religion, then to doubt it would have been to doubt the gods.

Today the word "science" has some of the connotations of magic in the non-scientific man's vocabulary. "Science reveals" a new substance to make his teeth whiter, a way to estimate his fitness for a job, a chance to cruise around the solar system. It is not easy for him to understand where science leaves off and science fiction begins.

His science-fiction expectations may become attached to his doctor, who is the only real live scientist he knows—a dispenser of "wonder drugs" and a performer of "life-saving operations."

Thus the doctor is a priest—in the old belief and in the new. He works with forbidden things, things beyond most people's knowledge. As one patient put it:

I respect doctors. I think they are like ministers. And it's hard work and a lot of grief. I wouldn't listen to troubles and work in blood the way they do.

. . . The doctor himself has a diffi-

cult time adjusting to his "differentness." It creates conflicts in his attitude toward his practice and in his relationships with his patients. He thinks that in order to keep his patients' confidence he must live up to a superman role . . . Yet if the medical profession . . . promotes illusion, [doctors] are immediately involved in a complex of ethical problems.

As one doctor said:

If the patient were to look upon the doctor as a man who is well trained in his field and to whom he can come for help, but who is certainly not omniscient or unfailing, we would probably have better results from medicine. [We] would also probably have less unethical conduct on the part of the doctors who may be unscrupulous. This is a very delicate situation to discuss because it is certainly good to have unquestioning faith in the ability of the doctor. Without faith a lot of healing could not be done. The situation still lends itself to a condition where many doctors might take advantage of the situation . . .

Another one spoke of the difficulty of competing with the "doctor next door" who is willing to use the present-day equivalent of magic:

. . . Patients have the idea that penicillin is a great medicine and they should have that for everything, including colds. And a patient will have a bad cold and come into the office and want a shot of penicillin. It's kind of hard sometimes to get around that. It's a matter of having that patient go next door to some other doctor, or of deciding to go ahead and give that shot of penicillin . . .

Another says:

. . . If you tell a patient that you don't know, he loses faith in you. I've seen a patient change from doctor to doctor until he found one that lied.

The question is difficult to deal with because the issues are not clear-cut. Faith in the doctor and in the treatment *is* a factor in healing. Patients *do* create pressures by being really personally dependent on their doctor or by demanding the exorcism of surgery. Less thoughtful doctors who exploit these attitudes in patients offer unfair competition to other doctors.

If the profession permits itself to slip into a belief that all patients have to have their doctors appear infallible—and their drugs "wonder" and their cures "miraculous" and

"No, no! Say Ah! not Ughhh!"

brand new

arlidin

helps your peripheral vascular patients

"strong muscle vasodilator activity and an adequate increase in cardiac output"[1]

In intermittent claudication
diabetic vascular disease
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arlidin* HCl
brand of nylidrin hydrochloride
tablets **6 mg.**
dose: 1 tablet t. i. d. or q. i. d.
bottles of 50, 100 and 1000.

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XUM

vasorelaxation
more tissue oxygen
improved muscle metabolism
pain relief
safe • rapid • sustained

walk longer, further, in more comfort

ARLIDIN dilates peripheral blood vessels in distressed muscles, relaxes spasm, increases both cardiac and peripheral blood flow... to send more blood where more blood is needed.

"safe vasodilative agent of minimal toxicity and optimal tolerance"[2]

1. Pomeranze, J. et al.: Angiology, June, 1955.
2. Freedman, L.: Angiology 6:52, Feb. 1955.

Write for samples and literature

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their operations "life-saving"—they are placing themselves in a vulnerable position, because they cannot deliver the goods.

Louis Regan, M.D., in his book, "Medical Malpractice," gives considerable attention to the "overoptimistic prognosis" as a starting point for many malpractice actions . . . He says: "The public should be informed as to (1) what constitutes malpractice, and (2) how really few cases of actual malpractice occur. There should be better understanding, too, of the physician's duties, his *capacities and limitations, of what may reasonably be expected of him*" (italics ours).

There is evidence . . . that doctors may be coming to believe that the aura of infallibility and the myth of the exact science are indispensable to the practice of medicine . . . They may be depending on each other collectively for protection in a false position. One doctor said, probably without realizing the full implication of his statement:

. . . If there was one definite way of doing a procedure, [then] anybody could be trained in a short time to do those procedures in a correct and exact way. But that condition does not exist . . . We're not dealing with machines; we're dealing with human beings. I think the matter of doctors banding together to protect each other—I think that is probably as much a part of the art of the practice of medicine as any individual doctor talking to his patient.

And another doctor analyzed it:

"No, not natural-born. I'm a Caesarean!"

FOR SUPERIOR PERFORMANCE

IN ANTIBIOTIC THERAPY

Polycycline—available in many dosage forms—affords significant clinical advantages in broad-spectrum antibiotic therapy:

EFFECTIVE IN BROAD RANGE
—against Gram-positive and Gram-negative organisms, certain rickettsiae and large viruses.

GREATER TOLERANCE
—markedly lower incidence and severity of adverse side effects.

GREATER SOLUBILITY
—than chlortetracycline, yielding quicker absorption and increased diffusion in body fluids and tissues.

GREATER STABILITY
—in solution than chlortetracycline or oxytetracycline, assuring higher, more sustained blood levels.

Polycycline is a tetracycline produced by the unique Bristol process of direct fermentation. Its basic structural formula is free of a chlorine atom (present in chlortetracycline), and of an hydroxyl group (present in oxytetracycline).

EFFECTIVE, SAFER, MORE SUSTAINED ACTION WITH THIS NEWEST BROAD-SPECTRUM ANTIBIOTIC

POLYCYCLINE AQUEOUS '250' or '125'
An aqueous suspension ready to use without reconstitution. Stable for 18 months without refrigeration. Highly palatable, cherry flavor. As calcium tetracycline equivalent to 250 mg. (or 125 mg.) tetracycline HCl per 5 cc.; in bottles of 1 fl. oz.

POLYCYCLINE SUSPENSION WITH TRIPLE SULFONAMIDES
Coconut oil suspension of tetracycline with three sulfonamides. In concentration of 125 mg. tetracycline HCl with 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine per 5 cc.; in bottles of 2 fl. oz.

POLYCYCLINE SUSPENSION '250'
A really palatable oil suspension, requiring no dilution or reconstitution. Needs no refrigeration—stable for 18 months. In concentration of 250 mg. tetracycline HCl per 5 cc.; in bottles of 1 fl. oz.

POLYCYCLINE CAPSULES
Handy form for oral use, in two potencies of tetracycline HCl. In capsules of 100 mg.: in bottles of 25 and 100. In capsules of 250 mg.: in bottles of 16 and 100.

POLYCYCLINE INTRAMUSCULAR
For deep intramuscular injection. In single-dose vials of 100 mg. tetracycline HCl per vial.

POLYCYCLINE OINTMENT
WITH 2% XYLOCAINE*
—30 mg. tetracycline HCl with 20 mg. Lidocaine (as the base), per gram.

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POLYCYCLINE AQUEOUS PEDIATRIC DROPS
As calcium tetracycline equivalent to 100 mg. tetracycline HCl per cc.; in bottles of 10 cc. with dropper calibrated at 25 mg. and 50 mg.

POLYCYCLINE PEDIATRIC DROPS
For accurate dosage in small amounts. In concentration of 100 mg. tetracycline HCl per cc.; in bottles of 10 cc. with dropper calibrated for administration of 25 mg. or 50 mg.

When you think of tetracycline, think of

POLYCYCLINE®

(Tetracycline HCl Bristol)

. . . When the doctor really feels he *is* God's right-hand man . . . it may have something to do with the general . . . antagonism toward doctors . . . So many of them behave as though they knew the answers, and people somehow know they don't. People generally know.

The doctor who says "If you tell them you don't know, they lose faith in you" is not looking far enough ahead.

He forgets that if you *don't* tell them and *they find out,* they not only lose faith; they are disillusioned and even vindictive.

Magazine editors whose business it is to gauge public response and thereby build circulation will not hesitate to exploit this bitterness, until the practicing physician may never know, when he approaches a treatment-room door, whether the patient on the other side thinks he is a god or a crook.

The good doctor doesn't want to be either.

. . . Some disillusioned patients said:

You know, a lawyer will defend you in court for no dough, but afterwards he doesn't strut like a god because he did it. Doctors are needed to keep you well, but they think too much of themselves.

They pass themselves off as being a part of a loftier profession . . . Other endeavors—where there is just as much service given—give it with more understanding and plain honesty.

They ought to stop selling doctors like they sell Rice Krispies. I'll take the Rice Krispies. At least I know what's inside matches the label.

One who was perhaps more balanced and realistic said:

When I put my case in a doctor's hands, I want the responsibility to be his, not mine. At the same time, I do object to that kind of a doctor who will not tell you anything and who wants you to trust him for everything. I think most of us are not morons. While we trust the doctor, we also like him to trust us and to believe that we can understand something about it and that we will cooperate better if we understand why. I trust the doctor more who trusts me more and tells me all about it—what his limitations are, as well as what are the limitations of medical science—instead of "Never mind, I'll take care of it!"

. . . So much has been published in the press about scientific advances in medicine that it has led many to expect all sorts of spectacular results which are not borne out by experience.

Perhaps organized medicine should begin to emphasize this fact. Perhaps the official attitude of organized medicine should be patterned on something more nearly like the classic humility of the old country doctor, who often said, "I have done all I can; we must leave the rest to God."

B. *The public and the profession need to understand at exactly what point the doctor can be expected to subordinate his normal self-interest*

in order to safeguard the patient's vital interests.

The concept of the dedicated profession probably derives from the ideal of the priesthood. It is a group of individuals, set apart from the rest of society, guaranteed by society a "living," [and] expected to perform, in return, a function of completely selfless service . . .

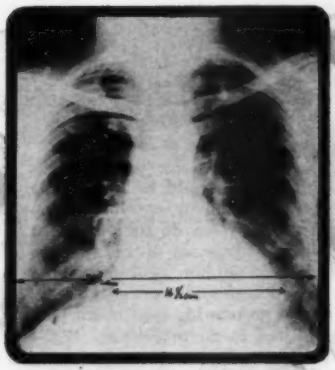
There are strong indications that the public expects the doctor to show a similar dedication . . . to forgo any thought of self-interest.

The demands that many people make upon the doctor indicate this—that he should come in the middle of the night without a murmur of complaint; that he shouldn't charge for any number of reasons (because he didn't find anything wrong, because he referred me to a specialist anyway, because he didn't cure the ache); that he shouldn't expect to be paid as rapidly as any other creditor.

The complaints that this group voices about his nice house in the best section of town and his new car indicate that they feel he has betrayed his dedication.

Some of their disappointment in doctors is reflected in the following negative expressions from patients:

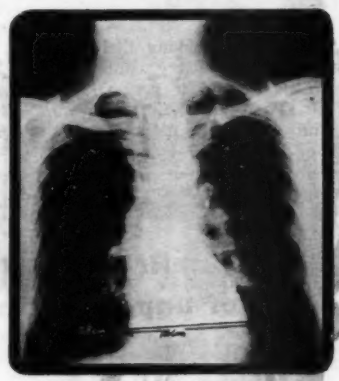
Once I had a doctor and he told me when I called him up: "It will cost you $12 to get me out of bed. Are you *that* sick?" And I said to him, "After you ask me that, I'll tell you—if it cost me just twenty cents, I don't want you to come out!" [MORE▶



BEFORE

ESSENTIAL
HYPERTENSION

(X-ray, enlarged heart)



AFTER

(X-ray, same heart after treatment)

The 2 X-rays above show the enlarged heart of a hypertensive patient before and after treatment with Unitensen Tablets. Unitensen is a true hypotensive drug that dependably lowers blood pressure—without dangerous side actions—in the majority of hypertensive patients whose blood pressure must be lowered. Thus, Unitensen can arrest the progress of vascular disease and, in time, actually permit regression of organic changes.

UNITENSEN® TANNATE TABLETS

brand of cryptenamine

Each tablet contains cryptenamine (as tannate salts), 2 mg.

Prolonged treatment is inexpensive—costs ⅓ to ⅕ less than other potent hypotensive drugs.

bottles of 50, 100, 500 and 1000

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Doctors think they're little tin gods, too. Well, maybe so . . . They are above and they should be above, but they're out for the dollars. In some ways they show it.

. . . Doctors should be like public schools . . . open to everybody who pays taxes. Now my doctor would just yell if he heard me say his bills are too high. If I did tell him, he'd just tell me that my chickens and eggs are too high. Then he'd go into his spiel about how long he had to go to college. But I don't tell him what our farm cost us or how long it took us to get where we are today.

. . . They're breaking their necks to get into the society column. My wife reads it, and it says Dr. This and Dr. That and their wives wore this and wore that. All of it comes out of their patients—patients who have to pinch to go to a movie on Saturday night.

Not all of them are bitter. Those who like their [own] doctor seem to be influenced partly by a feeling that he is more dedicated than other doctors:

. . . It is a fact that doctors' bills today are as high as a cat's back. Now they have been fair to *us*. But I know lots of times when other people got high bills . . . Maybe it's only when the doctor *knows* you [he] will give you good care and not go after your money.

I told him what our finances were and that I worked and what I earn. I have to take care of Mother. So he said not to worry, he wasn't going to make

Primum Non Nocere

The primary concern of the dermatologist is embodied in the dictum, "Primum Non Nocere," meaning *"First do no harm."*[1,2] A major attribute of Desitin Ointment is its non-sensitizing, non-irritant, non-toxic[4-6] quality even when applied over extensive, raw skin areas. To soothe, protect, lubricate, and accelerate healing ... without causing "therapeutic" or "overtreatment" dermatitis ... rely on

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OINTMENT

rich in **cod liver oil**

in **diaper rash • wounds** (especially slow healing)
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dermatoses • rectal irritation

Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars.

May we send **samples** *and literature?*

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1. Overall, J. C.: Southern M. J. 47:789, 1954. 2. Editorial: New England J. M. 246:111, 1952.
3. Grayzel, H. G., Heimer, C. B., and Grayzel R. W.: New York St. J. M. 53:2233, 1953.
4. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
5. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
6. Turell, R.: New York St. J. M. 50:2282, 1950.

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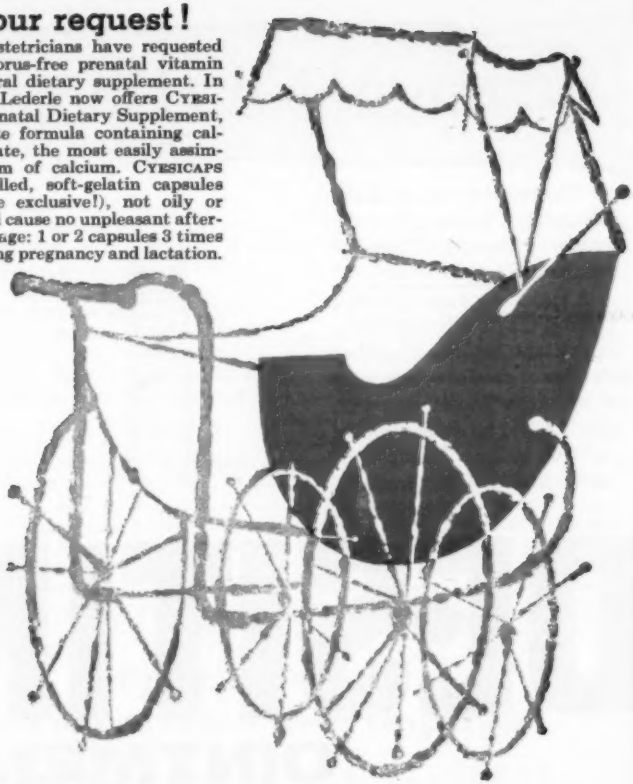

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Six capsules supply:
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much from me. He likes being a doctor, he said. His office is nice, but I saw him in his car one night and it's only a Chevvy. We're lucky!

The doctor himself is of two minds about the question of dedication and economics. The most typical reaction is: I didn't go into medicine to make money, but I have to make a living.

Most doctors in private practice seem to be acutely aware that they are on their own, that they do not have the kind of minimal security of the professional employed by an institution. Nor do they have the opportunity to build up a capital investment, as the businessman may have. They have only time and skill to sell. One surgical specialist expressed it:

. . . If we should lose our practice for some reason such as illness or death, our business is not worth anything . . . It isn't like a man who builds a retail store from the ground up and then . . . if he gets ill or goes away . . . his business goes on. A doctor's practice is absolutely personal, and without him being there to operate it, his business isn't worth anything . . . You can't build up a capital investment.

Most of the doctors interviewed display a consistent preoccupation with their economic insecurity . . . Yet over and over again, they express their distaste for discussing money with their patients, for revealing any interest in the finances of a relationship which they feel is expected to be purely altruistic. One doctor expressed the conflict vividly:

Anyone is worthy of his hire . . . If he does a job, he is supposed to get paid for it . . . You just hate to talk about money, especially when you save somebody's life, but you have got to be paid. If we had a course in business [sighs] in medical schools, I think we would be a whole lot better off . . . Some doctors have gotten around that by having an efficient secretary and they tell her to charge. She sends out all the bills and she knows . . . Most doctors are very, very diffident about saying anything about fees. And they've got to live. They've got to pay the rent. If they don't, they're no good to anybody. To their family or anybody. They've got to live.

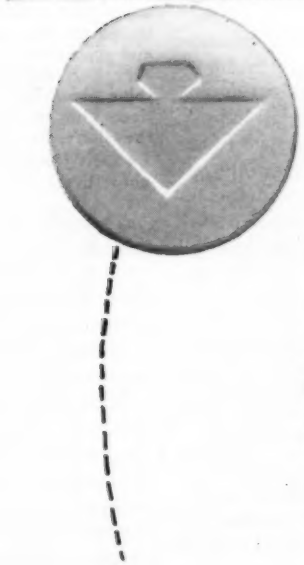
They also express pride in their individualism and are critical of other segments of the population for seeking too much security. Yet, at the same time, they often wish they were free of their own economic insecurities . . .

It seems evident that there is confusion in everybody's mind about altruism and self-interest. There is a feeling that the two conflict. This feeling is a source of unhappiness to doctors and a deep-rooted cause of public misunderstanding and resentment.

The doctor, in a culture where money is the measure of success, is not likely to resolve the conflict by becoming a pure altruist. Neither will anyone—doctor or patient—welcome the idea of a completely commercialized healing arts industry. So the conflict has to be resolved in some sort of compromise . . . [MORE ▶

ERIK NITSCHE

fast acting



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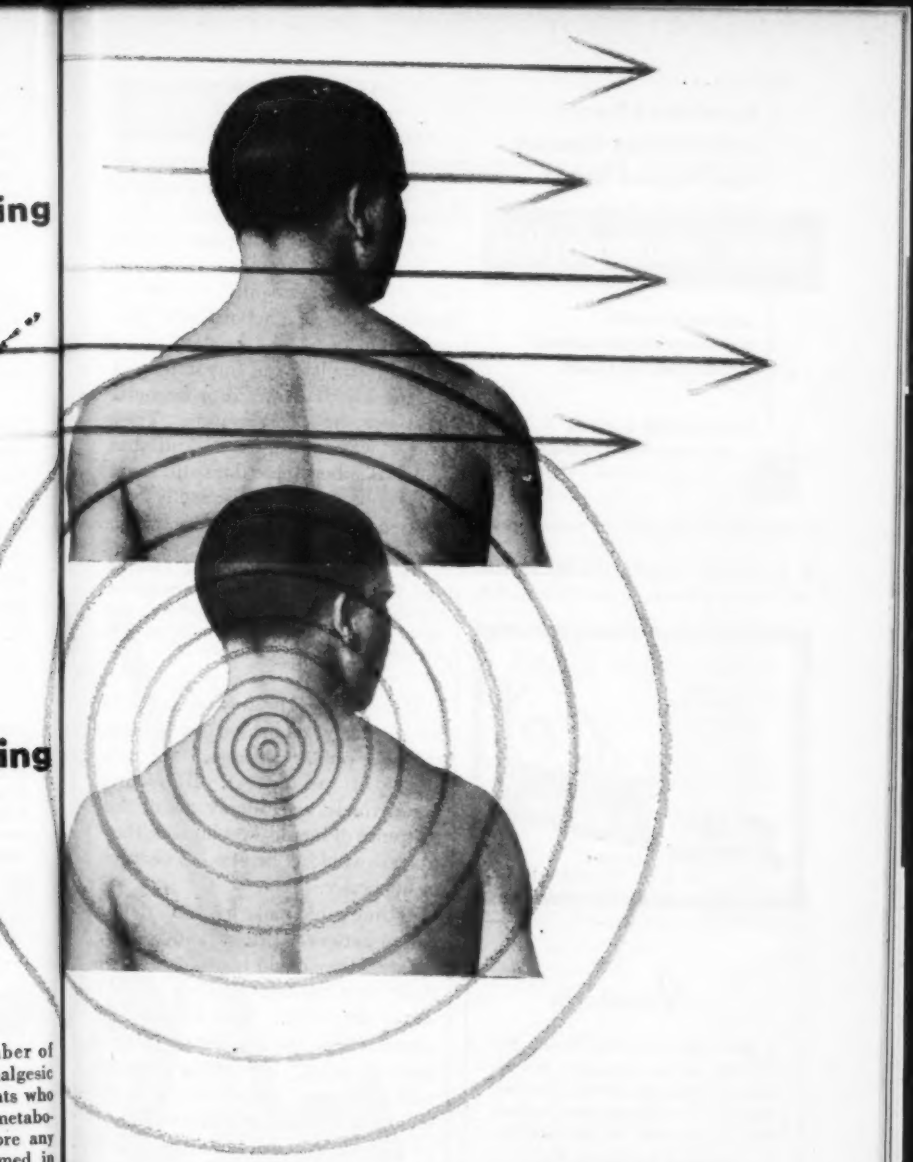

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One clue to a more satisfactory compromise lies in the wording of the first principle of medical ethics, which has perhaps not been taken literally enough: "The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration."

The formulators of this statement did not say that reward or financial gain was *no* consideration. They said it was *subordinate*. And that which is subordinate does still exist.

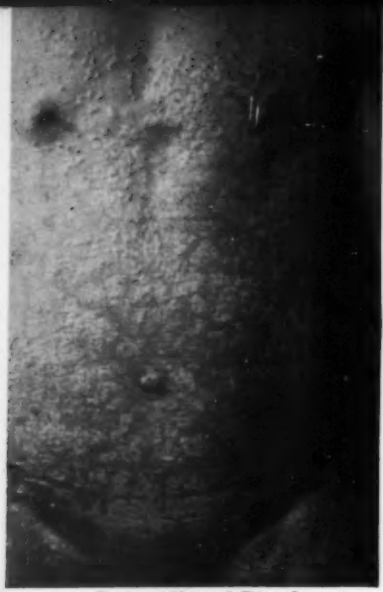
As one patient succinctly expressed it:

No doctor is going to take care of you for nothing—no reason why he should. He ain't no angel and he's entitled to a decent fee. Trouble is, not everybody can afford to pay it.

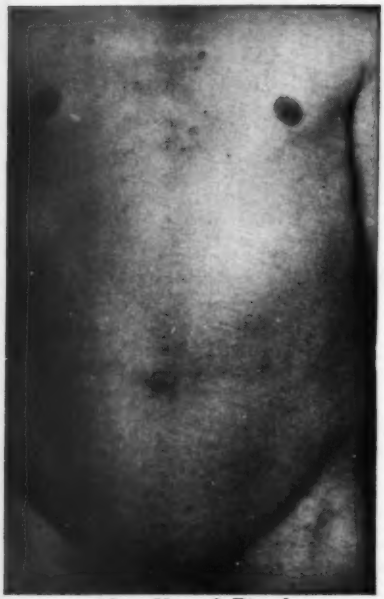
If the medical profession claims to be a purely dedicated profession, then the public will resent any evidence of self-interest. If doctors could freely and openly admit the existence of medical economics, they at least wouldn't be open to charges of hypocrisy.

If they could make a clearer delineation between "prime" and "subordinate," they could begin to resolve their own conflicts. [They could] say to the public: "Our self-interest operates like anyone else's—up to a certain point, the point beyond which its operation would be detrimental to the patient's vital welfare."

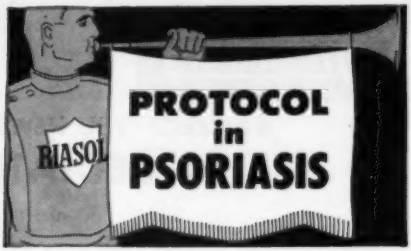
To sum up: . . . We must find ways for the individual doctor and



Before Use of Riasol



After Use of Riasol



In a recent article in the *British Medical Journal*, Ingram* emphasized three important points: (1) The disease is milder in summer. (2) Psoriasis is essentially an epidermal reaction and hence should receive local therapy. (3) Treatment must be continued until the skin is clear; not a single active lesion can be left if extension is to be avoided.

These lessons apply to RIASOL, the effective local treatment for psoriasis:

(1) Attack psoriasis in the summer, when treatment proves most effective.

(2) Prescribe RIASOL, which improved the skin patches in 76% of a series of cases in which other treatments had failed.

(3) Continue the use of RIASOL until every patch of psoriasis has disappeared, and in fact for several weeks afterwards.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

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*Ingram, J. T., Approach to Psoriasis, *British Medical Journal*, 2:591, 1953.

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RIASOL FOR PSORIASIS

the organized profession to reflect a more realistic picture to the public. If the public can be educated to expect and to appreciate what the doctor really can deliver, then doctors will be free to carry on their work in an atmosphere which is not so colored with tensions and hostility.

It may be said with certainty that if this confusion . . . is as widespread as our pilot study suggests, it will continue to contribute to the rising tide of malpractice suits and adverse publicity until corrective measures are taken.

WE THEREFORE RECOMMEND:

That the following conclusions be incorporated in the public relations policy of the American Medical Association:

A. That the public be informed to what degree medicine is an exact science and be informed that doctors are not infallible.

B. That the public be informed at exactly what point the doctor can be expected to subordinate his normal self-interest in order to safeguard the patient's vital interests.

If the Board of Trustees does not wish to adopt these conclusions as [public relations] policy without further study,

WE THEN RECOMMEND AS AN ALTERNATIVE:

That the validity of these conclusions be further tested, by developing an experimental program in a carefully selected community . . .

Section 3

The Disciplinary System of Medicine

At our request, the headquarters staff of the A.M.A. conducted a survey to determine to what extent the county societies are assuming responsibility for the maintenance of ethical standards.

Questionnaires were sent to all county medical societies in the United States and territorial possessions, requesting information on disciplinary actions taken . . . Approximately one-third of them (1,100) returned the forms. While not all counties responded, many of the larger societies are represented.

Over the past twenty-four months:

¶ Twenty-one doctors were *expelled* by these societies (ten for unspecified reasons, six for illegal acts, four for offenses against patients, one for an offense against colleagues);

¶ Twenty-one doctors were *suspended* by these societies (nine for unspecified reasons, seven for illegal

acts, five for offenses against patients);

¶ Seventy-nine doctors were *censured* (thirty-six for unspecified reasons, twenty-eight for offenses against colleagues, thirteen for offenses against patients, two for illegal acts).

This total of twenty-one doctors expelled in two years seems to indicate a lack of vigorous activity on the part of county societies in the supervision of their membership. We feel that because of their close professional and personal ties, members of county societies are unable to exercise the judicial and disciplinary functions . . .

By discussions with practicing physicians, hospital administrators, and professional hospital inspectors, we have found it is taken for granted that [discipline through] the hospital is the only realistic approach to supervision of doctors.

When questioned, these people point out (1) that only in the hospital are there systematic records, including pathologists' reports; (2) that the threat of losing hospital privileges makes the doctor willing to submit to professional discipline; (3) that the public's support of the accreditation program enhances the hospital's [disciplinary] strength . . .

It seems to us that something of professional unity and dignity is lost with the uncritical acceptance of this reasoning as the *total* answer to the problem. Furthermore, from the point of view of the public interest, it would seem that reliance on hospitals, one by one, for the maintenance of standards could well accomplish merely a division of the community's hospitals into two classes: hospitals staffed by conscientious men and hospitals for mavericks.

It might be that the profession would find the matter of self-discipline less vexing if some differentiation could be established between judgments of competence and judgments of ethics.

It is logical that the hospital be the setting for evaluating a man's *competence* in his work. Ideally, the hospital should provide the teaching environment in which a doctor could grow and learn from other doctors.

Once the question of competence is evaluated, however, there still remains the possibility that a man is not honest.

If he is a crook, in the considered judgment of his peers, he should be dealt with in some more conclusive fashion than the mere rescinding of his privileges in one hospital. He should be removed from the company of ethical physicians and deprived of their tacit endorsement.

We conclude from these studies that the present supervision of organized medicine over the ethical standards of doctors is not adequate . . . We wish to call this forcefully to the attention of the Board of Trustees and

WE [THEREFORE] RECOMMEND:

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That the Board direct the appropriate councils or committees to make a thorough study of the procedures which might be used to protect the public from unethical practices, including:

1. A definition of where the responsibility for the maintenance of ethical standards does lie;

2. More precise differentiation between ethics and professional etiquette;

3. And an investigation of the possibility for further cooperation between the state associations and the state licensing boards on the supervision of medical practice . . .

WE FURTHER RECOMMEND:

That when this study is accomplished and its conclusions implemented, the public be informed exactly where the responsibility does lie and what procedures are established for their protection; and that this clearer delineation be used to offset adverse reactions against the A.M.A. and the profession in general.

In making these recommendations, we are aware that the Judicial Council and the Council on Constitution and Bylaws are concerned about these questions. We wish only to suggest that our investigations emphasize the urgency of re-establishing medicine's position as a self-disciplining group. END

What Hospital Administrators Say

[CONTINUED FROM 103]

The physician is the last of the autocrats in our Western culture. The authoritarian tradition of medicine, which used to prevail throughout the hospital, now keeps colliding with the new, democratic concept of management.

The Way Out

How can such collisions be avoided? Or, if they can't be, how can the resulting sparks be prevented from starting so many fires?

Certainly the hospital isn't going to reverse itself and return to the autocratic system of caste and privilege, with the patient coming last instead of first. But it isn't sensible to expect the doctor to change, either. The surgeon who trains for a lifetime to maintain the absolute discipline he must have in the operating room isn't likely to shed his authority along with his mask and gown.

Nobody wants him to do that—least of all the hospital administrator, who understands well the need for clinical authority. What the administrator hopes is that the doctor may come to understand he can relinquish *some* authority outside the operating room and the sickroom without losing his prestige.

As a matter of fact, some observers think the doctor would gain in

public favor if he acknowledged more freely, as Dr. Elmer Hess has done, that there are others in the act besides himself.

It has been said that the sick man loves his own doctor, but that well people dislike doctors generally. If this is true, it may be because the sick person *needs* the security of being treated like a child. But the healthy adult wants to be treated as an adult.

The physician has nothing to fear in the struggle toward democracy. His place of honor in our society is not given him because we think him all-powerful. We honor him rather because he assumes the awful responsibility of trying to preserve life, because he is thus a little closer than the rest of us to the eternal mystery and the eternal truth. Because he does God's work of healing the sick, we've come to expect of him the godlike virtues of love, charity, and forbearance. Expecting these, we're shocked and bitter when he disappoints us and behaves like a human being.

The hospital administrator, I've learned, yields to no one in his admiration for the medical profession. He understands why the physician is cast in the role of God; and he's willing to settle for this—but with one condition: The God that the hospital administrator has in mind is not always Jehovah shouting angrily at Job from the whirlwind. Sometimes, instead, He is the gentle Christ saying, "Blessed are the meek." END

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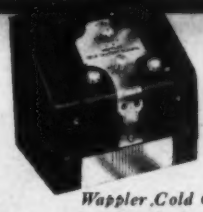

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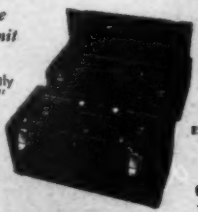

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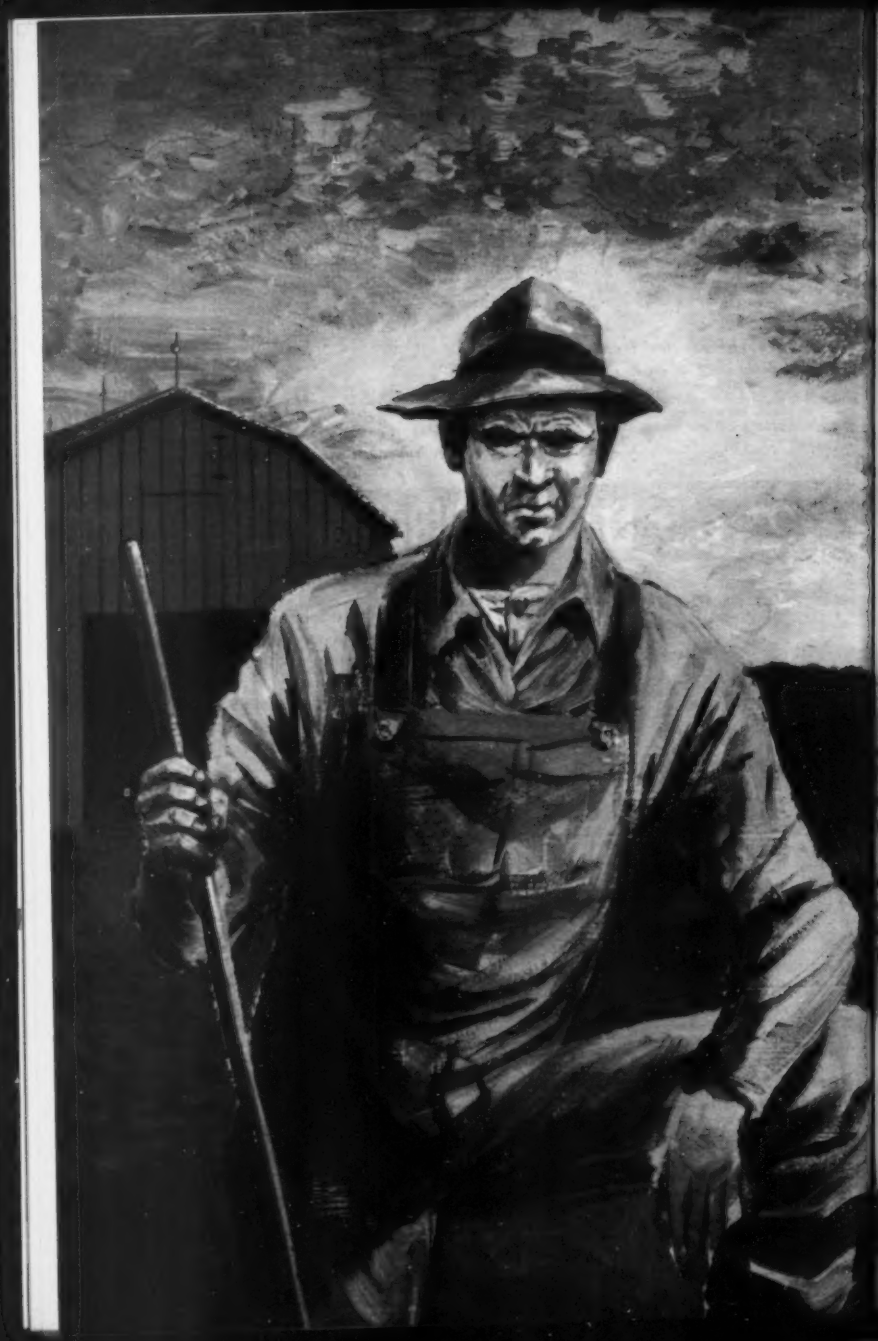

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1. Donovan, E. J.: Diagnosis and Treatment of the Irritable Colon Syndrome, Rocky Mountain M. J. 50:952 (Dec.) 1953.
2. Butler, T. C., Mahaffee, C. and Waddell, W. J.: Phenobarbital; Studies of Elimination, Accumulation, Tolerance, and Dosage Schedules, J. Pharmacol. & Exper. Therap. *111*:425 (Aug.) 1954.
3. Shideman, F. E.: Sedatives and Hypnotics II: Barbiturates in Drill, V. A.: Pharmacology in Medicine, New York, McGraw-Hill Book Company, Inc., 1954, p. 14/10.

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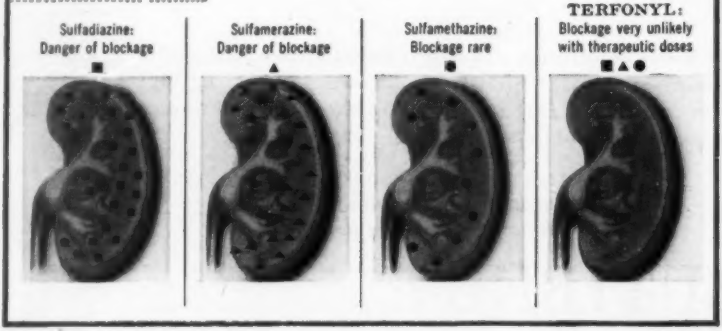

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Memo

FROM THE PUBLISHER

What's Troubling You?

About eighteen months ago, a physician named Herbert S. Simpson of Bedford Hills, N.Y., sent us a letter. Dr. Simpson, the president of the Westchester Academy of General Practice, wrote as follows:

"I should like to introduce you to a problem which, to me at any rate, is very important from an economic point of view . . . The cost of malpractice insurance in New York State is exorbitant and rapidly becoming prohibitive . . .

"I am writing this to you because of your excellent record in the interest of the economic status of the American physician. I hope that you may be able to investigate this problem thoroughly . . .

"I shall be glad to refer you to men who are closer to the problem than I. Thank you for any time you may give this letter . . ."

As it happened, we gave Dr. Simpson's letter a lot of time, for it posed a critical problem in present-day medical practice.

It led directly to five major articles on malpractice insurance, including "Malpractice Postscripts" in this issue. It thus produced answers of direct interest not only to the letter-writer, but to his colleagues the country over.

Like Dr. Simpson, many other medical men send us practice-connected queries. Several thousand a year, in fact, raise questions as far-ranging as these:

¶ "How can I get maximum liquidation value out of my practice on retirement?"

¶ "What's the best type of health and accident insurance for me?"

¶ "Is it possible that I could increase my earnings by reducing my fees?"

If these questions sound familiar, it's because we've answered them recently in MEDICAL ECONOMICS. And if they remind you of problems *you've* encountered, why not do what the above-mentioned doctors did?

To make it easy for you, we've provided a suggestion blank on the following page. You're invited to jot down the gist of the economic problem you'd like to see us explore, giving enough details so that our editors will know exactly what you have in mind.

Filling out the blank takes less than a minute. But it may well bring you some especially rewarding reading in our subsequent issues.

Every month, of course, our staff seeks out the professional problems of the moment during field trips and personal interviews. We'll welcome your contribution none the less. It may reshape research already under way; or it may suggest entirely new

lines of research. So tell us, if you will, in a couple of dozen words or so:

What economic problem have you encountered recently that you'd like to read more about in our pages?

We're listening . . .

—LANSING CHAPMAN

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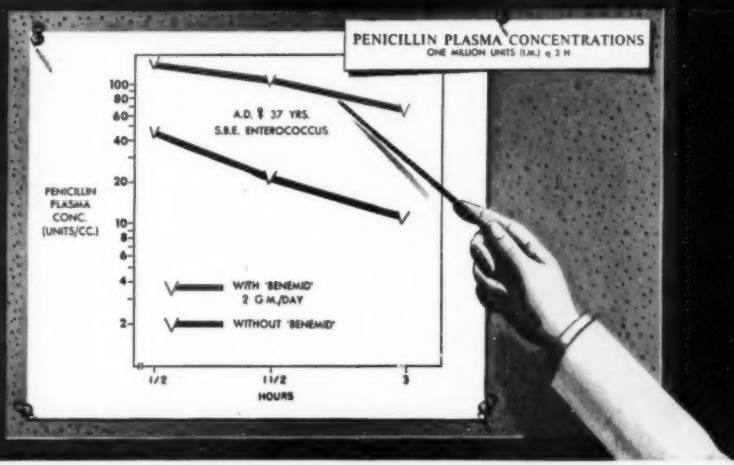

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References: 1. Antibiotics & Chemotherapy 2:555, 1952. 2. A.M.A. Exhibit, June 1951.

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